Supreme Court, U.S.
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No.

IN THE
Supreme Court of the United States

KIRK TEDFORD,

Petitioner,

v.

BENCHMARK INSURANCE COMPANY AND THE FUTURE EQUIPMENT COMPANY, INC. EMPLOYEE WELFARE BENEFIT PLAN

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR A WRIT OF CERTIORARI

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35 pp

QUESTION PRESENTED

In this case, the Fifth Circuit held, in conflict with decisions of the Second, Third, Fourth, Sixth, Seventh, Eighth, and Ninth Circuits that when an insurance claims administrator for an ERISA employee medical benefits plan denies coverage based on a factual determination, its factual determination is reviewable only for abuse of discretion – even where the claims administrator has not been delegated authority under the plan to make final and binding determinations. The case presents the following question:

Whether an ERISA plan participant is entitled to *de novo* review of an insurance claims administrator's fact-based decision to deny coverage for medical benefits when the claims administrator has not been delegated the authority under the plan to make final and binding determinations?

RULE 14.1(b) STATEMENT

Pursuant to the Court's Rule 14.1(b), petitioner states that the parties in the court of appeals, who are respondents here, are Benchmark Insurance Company and the Employee Welfare Benefit Plan sponsored by Future Equipment Company, Inc., defendants-appellees.

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PETITION FOR A WRIT OF CERTIORARI

Kirk Tedford respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit.

OPINIONS BELOW

The trial court's opinion is included at App.8a - 25a. The court of appeals' opinion is included at App. 1a- 7a. The appendix is attached.

JURISDICTION

The court of appeals entered judgment on June 17, 2002. This Court has jurisdiction under 28 U.S.C. § 1254(1).

AND STATUTORY PROVISIONS INVOLVED

The pertinent provisions of the Employee Retirement and Income and Security Act of 1974 (ERISA) § 503, 29 U.S.C. § 1133; §3(16)(A)(ii) and (B), 29 U.S.C.1002; ERISA § 404(a)(1) 29 U.S.C. §1104; and ERISA §402(a) 29 U.S.C. § 1102 are included at App. 26a -27a, attached.

STATEMENT OF CASE

A. Facts. On November 5, 1999, Kirk Tedford was injured in a motorcycle accident. As a result of a severe head injury, Tedford remained comatose for three weeks. On being discharged from Harris Hospital in early December, 1999, Tedford requested his medical bills be paid by his medical benefit plan. (R.941)[1]

1. The Administrative Process. Tedford was a participant in an employee welfare benefit plan sponsored

[1] "App. _ " references are to the attached appendix, and "R. __" references are to pages in the original five volume district court record prepared for the court of appeals.

by Future Equipment Co., Inc. (the Plan). Future Equipment purchased a group medical insurance policy underwritten by Benchmark Insurance Company (Benchmark), effective from June 1, 1999, to May 31, 2000. (R. 195) The Certificate of Insurance was issued to the Plan by National Heath Care Trust (Trust), a Mississippi Trust established by Corporate Benefit Services of America, Inc. (CBSA) as Trustor.

Benchmark also contracted with CBSA to adjust claims within written guidelines and parameters pre-approved in writing by Benchmark. CBSA received Tedford's hospital records on March 15, 2000. (R.784) The hospital bill was $173,755.56, and all medical bills totaled $229,329. (R. 303, 944) On March 21, 2000, CBSA denied coverage, claiming that at the time of the accident Tedford was intoxicated and using illegal drugs. (R.189) CBSA reached this conclusion based solely on a report in the hospital records that stated "ethyl alcohol" of "142H." The report stated that "this alcohol result is for medical purposes only. It is not a forensic order." Then, under "INTERPRETIVE NOTES" it indicated "100 mg/dl – may be intoxicated." (R. 334) The toxicology report also indicated "amphetamines-positives" and "opiates-positive." (R. 335) CBSA's denial of coverage rested on this Certificate provision:

> Benchmark shall not be liable for any losses sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(R.274)

On April 24, 2000, before the Benchmark policy terminated, Tedford appealed CBSA's initial decision denying coverage to CBSA, contending he had not

consumed opiates or amphetamines, and suggesting these were administered to him while he was unconscious. He also asserted he was not intoxicated, and that the accident was not a consequence of the consumption of alcohol. (R.617-19) Though CBSA never talked to or requested any further information from Tedford, it denied his appeal on July 22, 2000. (R.192-193)

2. CBSA Was Not the Plan Administrator or Fiduciary. Future Equipment purchased employee medical insurance for the Plan when it signed an EMPLOYER'S SUBSCRIPTION AGREEMENT, which provides:

> If approved, the employer understands and agrees that the trustee, administrator [CBSA] and the insurer [Benchmark], jointly or severally, are not now and shall not become under the Trust Agreement an administrator or fiduciary for any purpose whatever under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other law.

(R.195-196)

The CERTIFICATE OF GROUP INSURANCE the Trust issued to Future Equipment provides:

> By purchasing this coverage, an employer is establishing an Employee Welfare Plan, and may therefore be subject to compliance with the Employee Retirement Income Security Act of 1974 (ERISA). Benchmark, in performing its obligations under the policy, is acting only as a health insurer with respect to the policy and is not in any way acting as a plan administrator, a plan sponsor or a plan trustee for the purpose of ERISA . . . . The Administrator [CBSA], in performing its obligations under the terms of an

> agreement with Benchmark, is not acting in any way as a plan administrator, a plan sponsor or a plan trustee for the purposes of ERISA . . . .

(R.199)

The BENCHMARK GROUP MEDICAL INSURANCE POLICY, issued by Benchmark to the Trust, provides:

> Benchmark, in performing its duties and obligations under this policy, is acting only as a health insurer with respect to this policy and is not in any way acting as a plan administrator, a plan sponsor, or a plan trustee for the purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other federal or state law. The Administrator [CBSA], in performing its obligations under the terms of an agreement with Benchmark, is not acting in any way as a plan administrator, a plan sponsor or a plan trustee for the purposes of ERISA, as amended, or any other federal or state law.

(R.736) Neither Benchmark nor CBSA were named fiduciaries in the Plan documents, as required under 29 U.S.C. §402a (App. 26a), and Benchmark and CBSA three times expressly disclaimed that either would serve any role as the Plan administrator or fiduciary for purposes of ERISA.

3. CBSA Was Not Delegated Authority To Make Factual Determinations or Approve Large Claims. In the ADMINISTRATIVE AGREEMENT between Benchmark and CBSA, Benchmark expressly prohibited CBSA from approving a claim like Tedford's. CBSA and Benchmark's ADMINISTRATIVE AGREEMENT provides:

> Administrator [CBSA] shall process, investigate, settle and pay all valid claims, including expenses incurred in the investigation and settlement thereof, arising under Group Master Policy or Policies, subject to the supervision of the Company and in accordance with the terms and provisions of the Group Master Policy or Policies and guidelines recommended by Administrator and approved in writing by the company. All such claims shall be handled in a manner and under standards customary to the insurance industry and as required by applicable law. In addition, any single health claim payment in the amount of $10,000 to $24,999 shall be sent to the Company for review after being paid, while any single health claim payment in the amount of $25,000 or more shall require the Company's prior approval before being paid. For any claimant where the diagnosis is such to indicate that the total health claims cost may exceed $50,000, the situation shall be brought to the immediate attention of the Company when Administrator receives notice of that diagnosis.

(R.165-166)

These provisions do not delegate to CBSA the authority to "make an independent determination of the applicant's eligibility for benefits under the Plan [where] that decision 'shall be final and conclusive upon all persons if supported by substantial evidence'." *Wildbur v. Arco Chemical Co.*, 974 F.2d 631, 637 (5th Cir. 1992), *modified by,* 979 F.2d 1013 (5th Cir. 1992). No decision by CBSA approving Tedford's eligibility for benefits would be a "final determination binding" on Benchmark, who alone could approve Tedford's claim.

B. The Judicial Proceedings Below. Tedford filed suit in state court against Benchmark, which removed the case to federal district court in the Northern District of Texas. The parties agreed that all issues could be decided by the Magistrate. The Future Equipment Employee Welfare Benefit Plan was added as a defendant. Defendants moved for summary judgment, and Tedford filed a response and cross-motion for summary judgment. In his response, Tedford challenged the accuracy and sufficiency of the administrative record submitted by CBSA. He requested a *de novo* trial to establish whether CBSA's denial of coverage was correct. Tedford contended that no deference should be accorded CBSA's administrative decision denying the claim because CBSA was not the Plan Administrator, was not an ERISA fiduciary, and had not been delegated discretionary authority to make final and binding decisions of fact or plan interpretation. Tedford argued that CBSA's decision was entitled to no judicial deference because CBSA had no authority to approve Tedford's claim. Finally, Tedford contended that coverage could not be denied based on the evidence in the administrative record because Mississippi law, which was incorporated into the plan provisions, prohibited the use of hospital record test reports as a basis for denying coverage.

The factual reason CBSA gave Tedford for denying coverage under the policy was:

> According to the medical records obtained from Harris Methodist Fort Worth Hospital, Mr. Tedford's toxicology report of November 6, 1999 indicates a blood alcohol level of 142. By the hospital's own measures, blood alcohol levels in excess of 100 mg/dl means the patient may be intoxicated. This same toxicology report also

shows Mr. Tedford positive for opiates and amphetamines. Opiates are a synthetic narcotic.

(R.193) CBSA denied coverage under a Mississippi policy issued by a Mississippi Trust, which specified Mississippi law applied, solely on the basis of hospital test results of drug and alcohol concentrations, even though MISS. CODE ANN. §63-11-45 prohibited it from doing so.[2]

1. The District Court's Decision. The trial court recognized that *de novo* review of CBSA's decision denying Tedford benefits was required "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." (App. 11a) This result is dictated by ERISA § 503, which requires every employee benefit plan to "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. §1133. (App. 27a) Even though CBSA had continually disclaimed any status as a

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[2]MISS. CODE ANN. § 63-11-45 provides:

> Denial of insurance coverage on ground of refusal to submit to test or upon basis of test results. No coverage otherwise afforded under any policy of insurance shall be denied on the ground that any person has refused any test provided for by this chapter nor on the basis of the results of any such test. Any provision to such effect in any insurance policy hereinafter issued shall be void.

MISS. CODE ANN. § 63-11-3(c) defines "such test" as any "chemical test" that is an "analysis of a person's blood, breath, urine or other bodily substance for the determination of the presence of alcohol . . . ." Those performing "such tests" include "emergency medical personnel, nurses and doctors." MISS. CODE ANN. § 63-11-3(f). A person can be convicted of DWI on such test results, but insurance coverage cannot be denied on the basis of such test results.

fiduciary under ERISA, the trial court concluded CBSA was a fiduciary, reasoning:

> The validity of these disclaimers is questionable at best, and in fact, the Defendants now assert that their own disclaimers are void. A disclaimer of the role of the plan administrator may be permissible because when no administrator is specifically designated by the plan, the plan sponsor becomes the plan administrator by statute. 29 U.S.C. § 1002(16)(A)(ii), (B). But attempts to renounce a fiduciary role do not appear to be authorized by ERISA. To the contrary, except in limited circumstances not applicable here, a provision in an agreement or instrument purporting to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under ERISA is void as against public policy. 29 U.S.C. § 1110(a). *Cf. Custer v. Pan Am. Life Ins. Co.*, 12 F.3d 410, 418 n. 3(4th Cir. 1993)(noting that contractual disclaimer of ERISA fiduciary status should not be determinative, discretionary functions performed should control).

(App. 12a) After declaring that the disclaimer of CBSA's fiduciary role was illegal and void, and even while acknowledging CBSA had no authority to approve Tedford's claim, the trial court applied the unique rule in the Fifth Circuit requiring deference to all factual findings of ERISA plan fiduciaries.

> Regardless of the discretion, if any, that the plan grants to its administrator or fiduciaries to interpret the plan terms, the Fifth Circuit holds that factual determinations under ERISA plans are to be reviewed under an abuse of the discretion

> standard. *Pierre v. Connecticut Gen. Life Ins. Co.*,932 F.2d 1552, 1562 (5th Cir. 1991), *cited in Bratton*, 215 F.3d at 523. The Fifth Circuit distinguishes *Bruch* as limited to matters of plan interpretation when the facts are not in dispute, and ruled that the federal courts owe due deference to factual determinations made during the benefit review process. *Bratton*, 215 F.3d at 522; *Pierre*, 932 F.2d at 1562. Because Tedford is contesting findings that are factual rather than interpretative in nature, an abuse of discretion standard is appropriate.

(App. 14a-15a)

The trial court's reasoning started with the major premise of the Fifth Circuit's rule first articulated in *Pierre*: If any plan fiduciary decides factual issues in denying benefit coverage, then its findings of fact are entitled to trial court deference and review under the abuse of discretion standard. The trial court then used this minor premise: CBSA decided factual issues in determining benefit coverage. Therefore, the trial court concluded: "In reviewing whether there has been an abuse of discretion, the court must analyze whether the plan administrator acted arbitrarily or capriciously in making his determination." (App. 15a). Under the *Pierre* rule, even where an administrator or plan fiduciary is not delegated any discretion to make factual determinations that are binding on both the plan and participant, Fifth Circuit courts defer to those factual determinations, and always review them under an abuse of discretion standard.

The trial court followed *Pierre*, deferring to what it characterized as the factual determinations of a plan fiduciary, even though CBSA was not delegated discretion to make final and binding decisions about claims

eligibility. *Pierre's* extreme consequence is illustrated by this case. Here, the insurer and its claims-adjustor made absolutely clear that neither was the Plan administrator or fiduciary for ERISA purposes. Then, the Benchmark agreement with CBSA made it impossible for the claims-adjustor to approve Tedford's claim unless the insurer approved it first. Nonetheless, the trial court felt constrained to follow *Pierre* and deny Tedford *de novo* review of CBSA's denial of his claim.[3]

How important *de novo* review was to Tedford is illustrated in the trial court opinion. Having invalidated the disclaimers, and having found "discretion" to deny Tedford's claim was delegated to CBSA, the trial court then took the next step dictated by Fifth Circuit law. *Pierre* required the trial court to review CBSA's decision under an arbitrary and capricious standard. The trial court noted:

> Because a decision whether an abuse of discretion has occurred is based upon information known to the administrator at the time he made the decision, the court is generally confined to the record available to the administrator when receiving the factual determinations underlying denial of a claims.

(App. 16a) This doctrine originates in the Fifth Circuit decision in *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 299 (5th Cir. 1999) *en banc*, which the trial court

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[3]CBSA was not delegated discretion to interpret the policy. Nonetheless, the trial court upheld the claims-adjustor's interpretation of the Certificate even though CBSA ignored the unambiguous policy provision incorporating Mississippi law which prohibits denial of insurance coverage based on alcohol or drug tests administered for medical purposes at hospitals.

cited. *Vega* restricts trial court review to the administrative record submitted to the court by the defendants. As the trial court noted, "The Fifth Circuit has directed the district courts to consider whether the record that was developed adequately supports the administrative determination." (App. 18a) Evidence outside CBSA's administrative record could not be considered.

The trial court, in applying the Fifth Circuit rules in *Pierre* and *Vega,* decided this issue: Did CBSA act arbitrarily and capriciously in denying Tedford's claim, based on the record it had assembled, recognizing it was under "no specific duty to conduct a reasonable or good faith investigation . . ." (App. 17a) The trial court concluded CBSA's denial of the claim was not arbitrary and capricious based on the record CBSA assembled, even while it acknowledged "the court agrees that the documentation is not a model of organization" (App. 20a) *and that CBSA's conclusion that Tedford used narcotics was false* because "Tedford was given several medications en route to the hospital (and before being tested), but CBSA either did not have this report or did not appreciate its import prior to denying Tedford's claim" (App. 19a).

Tedford requested *de novo* review. Had he prevailed it would have dramatically changed the issue the trial court would have to decide. Tedford wanted the trial court to decide whether the accident was a consequence of his intoxication or use of illegal drugs. That was not decided. Instead, the trial court decided that CBSA had included enough information, even if some was false, to preclude the court from finding CBSA had acted arbitrarily and capriciously in denying the claim, based solely on the administrative record CBSA assembled.

2. The Fifth Circuit's Decision.

The Fifth Circuit affirmed, incorrectly referring to CBSA as the plan administrator and ignoring that it had not been delegated interpretive authority with respect to the Plan. The Fifth Circuit implicitly took *Pierre* two steps further. Not only did the Fifth Circuit affirm the trial court's deference to a claims-adjustor's decision denying benefits where the plan did not delegate to the claims-adjustor either discretion to interpret the plan or to make final factual determinations, it did so even though (1) the decision-maker was expressly prohibited by its contract with the insurer from approving a claim as large as Tedford's and (2) both the decision-making claims-adjustor and the insurer expressly disavowed that either was the Plan administrator or fiduciary for purposes of ERISA.

REASONS FOR GRANTING THE WRIT

This case presents an important issue covering the administration of ERISA over which the lower federal courts are irreconcilably divided, with the Fifth Circuit adhering to a position uniformly rejected by other circuits Both *Pierre* and the decisions below in this case, extending deference (1) of those who represent they are not plan administrators or fiduciaries, (2) where the decision-maker is not delegated authority to make binding decisions, but (3) is prohibited from doing so, should be reversed. Where the person or entity deciding claims eligibility is not a plan administrator or fiduciary for ERISA purposes, and is not delegated authority under the employee benefit plan to make final determinations about coverage, then the decision denying coverage should be entitled to no deference by trial courts. Reversing *Pierre* is all the more important when it is viewed in conjunction with Fifth Circuit doctrine set forth in *Vega,* that in

making a decision denying a claim, the decision-maker is under no duty to make a reasonable investigation of the claim, and a trial court cannot consider evidence relating to factual disputes other than such information as the insurer includes in its file upon which it relied in denying the claim. Trials in courts of factual disputes should be *de novo*, like any breach of contract lawsuit. Before this case, *Pierre* stood alone as an unfortunate anomaly. Now it has been carried to its extreme.

I. The Fifth Circuit's Requirement that Trial Courts Review All Factual Decisions Under The Abuse of Discretion Standard Conflicts With Decisions in Six Circuits, Which Apply the *De Novo* Standard of Review Unless the Plan Expressly Grants Discretion to a Fiduciary to Make Final and Binding Factual Determinations. The Fifth Circuit alone holds that even where the employee benefit plan does not delegate to the plan administrator or fiduciary the discretion to make factual determinations about benefit eligibility, the trial court nonetheless should defer to the factual findings of the decision-maker, reviewing the decision under an abuse of discretion standard rather than *de novo*. *Pierre v. Conn. Gen. Life Ins. Co.*, 932 F.2d 1552 (5th Cir. 1991) *cert. denied* 502 U.S. 973 and *Estate of Bratton v. National Union Fire Ins. Co.* 215 F.3d, 516 (5th Cir. 2000). The dissent from the denial of certiorari in *Pierre* by Justices White and Blackmun noted a conflict between the Fifth Circuit decision and the Third Circuit decision in *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176 (3d Cir. 1991), the Fourth Circuit decision in *Reinking v. Philadelphia American Life Ins. Co.*, 910 F.2d 1210 (4thCir. 1990), and by *dicta* the Seventh Circuit decision in *Petrilli v. Drecksel*, 910 F.2d 1441, 1446 (7th Cir. 1990). *Pierre*, 502 U.S. at 973.

In *Luby, supra*, at 1183, the Third Circuit, three months after *Pierre* was decided, rejected the Fifth Circuit's position, noting:

> We are likewise not convinced by the [*Pierre*] rationale . . . holding that administrator's factual determinations should be subject to deferential review. Plan administrators are not governmental agencies who are frequently granted deferential review because of their acknowledged expertise. Administrators may be laypersons appointed under the plan, sometimes without any legal, accounting, or other training preparing them for their responsible position, often without any experience in or . . . little knowledge of the rules of evidence or legal procedures to assist them in fact finding.

Since the Court denied certiorari in *Pierre*, the rejection of the *Pierre* doctrine by the other Circuits has intensified. In addressing *Pierre*, the Seventh Circuit said: "We do not agree with that court's conclusion because *Pierre* is fundamentally inconsistent with Trust law" and "inconsistent with the Supreme Court's rejection in *Firestone* of the argument . . . ." *Ramsey v. Hercules, Inc.*, 77 F.3d 199, 204 (7th Cir. 1996). Other points in *Pierre* that the Seventh Circuit found "similarly unpersuasive" included the Fifth Circuit's "assuming administrators are unbiased fact finders like the courts" and the "fear of a flood of litigation . . . ." *Id.* at 205.

In *Dvorak v. Metro. Life Ins. Co.*, 965 F.2d 606, 609 (8th Cir. 1992), the Eighth Circuit rejected the insurer's request that the court show deference to the insurer's decision even though the plan did "not give Metropolitan the requisite discretionary power" that would call for judicial deference. *See also, Donatelli v. Home Ins. Co.*,

992 F.2d 763, 765 (8th Cir. 1993); and *Riedl v. Gen. Am. Life Ins. Co.*, 248 F.3d 753, 756 (8th Cir. 2001) ("We hold that absent language in the plan granting discretionary authority to the administrator to determine eligibility for benefits or to construe the terms of the plan, fact-based determinations should receive *de novo* review.")

The Ninth Circuit rejected *Pierre* in *Walker v. Am. Homeshield Long Term Disability Plan*, 180 F.3d 1065, 1069-70 (9th Cir. 1999), stating: "[W]e acknowledge but disagree with the Fifth Circuit's view in *Pierre*" and holding "that *Firestone* did not leave open the issue of whether factual determinations should be reviewed under a different standard than plan interpretations."

In *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 250-51 (2d Cir. 1999), the Second Circuit disagreed with *Pierre's* holding that *de novo* review does not apply to fact based determinations in the absence of plan language granting discretionary authority. The Sixth Circuit has also followed the other Circuits in not adopting *Pierre*. *Delk v. Ford Motor Co.*, 96 F.3d 182 (6th Cir. 1996), *cert. denied*, 520 U.S. 1275 (1997). *See also Rowan v. UNUM Life Ins. Co. of Am.*, 119 F.3d 433, 435-36 (6th Cir. 1997). Several district courts in the First Circuit have rejected *Pierre*. *See Cleary v. Knapp Shoes, Inc.*, 924 F.Supp. 309, 313 n. 5 (D. Mass. 1996); *Jorstad v. Conn. Gen. Life Ins. Co.*, 844 F.Supp. 46, 54 (D. Mass. 1994); and *Grady v. Paul Revere Life Ins. Co.*, 10 F.Supp.2d 100 (D.R.I. 1998).

Pierre has been expressly rejected by courts in the First, Second, Third, Fourth, Sixth, Seventh, Eighth, and Ninth Circuits. Unfortunately, the trial court in this case was bound to follow *Pierre*, and deferred to the claims-adjustor's decision denying coverage even though no

language in the Plan delegated such authority to CBSA, and even though the agreement between CBSA and the insurer denied the claims-adjustor authority to approve Tedford's claim. The Fifth Circuit's rote affirmance reflects its rigid adherence to the rule despite its uniform rejection elswhere.

II. *Pierre* Thwarts the Goals of ERISA. ERISA was intended to provide federal assurance that employees who are promised benefits get them. To ensure this, ERISA § 404(a)(1) provides that "a fiduciary shall discharge his duties with respect to the plan solely in the interests of participants and beneficiaries and for the exclusive purpose of providing benefits to participants and beneficiaries." 29 U.S.C. § 1104. ERISA § 503 requires that the Plan provide the employee whose benefit claim has been denied the right to appeal that decision "for a full and fair review by the appropriate named fiduciary . . . ." 29 U.S.C. § 1133. The fiduciary should put the interests of the employees before its own or the insurer's interests. How far ERISA falls short of this goal in the Fifth Circuit is illustrated in this case.[4]

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[4]Lorraine Schmall, *Toward Full Participation and Protection of the Worker With Illness: The Failure of Federal Health Law After McCann v. H&H Music Co.*, 29 Wake Forest L.R. 781 (1994):

> Existing laws are ineffective to ensure that the worker with illness has adequate health care coverage. ERISA and other potential sources of federal statutory protection of the ill or disabled employee . . . fail. Absent a clear statutory mandate to the contrary, the courts have been content to defer to the business judgment of the plan trustee, and to construe provisions against protection. The result is often catastrophic for the worker, resulting in loss of coverage and loss of job, if not total destitution from

ERISA was passed to protect employees.[5] Under ERISA, a fiduciary is required to fairly decide when claims should be paid. ERISA is silent on how disputes concerning benefits should be resolved. Consequently, the courts decided the procedure for claims review. When disputes about benefit eligibility arose, plan sponsors, under employer established and administered plans, were analogized to trustees of a trust fund, who protect the corpus as well as pay the beneficiaries under the plan provisions. If the trust instrument authorized the trustee to make discretionary determinations about the proper interpretation of the trust instruments and to decide benefit eligibility, courts were reluctant to second guess those decisions, absent proof of abuse of discretion. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court applied principles of trust law to decisions on benefit claims where the trust instrument expressly provided the fiduciary-administrator with

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impossibly high bills.

[5] Alison Rozbruch, *Resolving the Conflict Between Two Visions For A Standard of Review In ERISA Denial of Benefit Claims*, 9 J.L. & Pol'y 507-508 (2001):

> "Congress enacted ERISA in 1974 after a decade of work on pension and employee benefit issues." ERISA's stated purpose is to uniformly protect "the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by proving for appropriate remedies, sanctions, and ready access to federal courts." Although the Act purports to protect participants, judicial decisions continually interpret ERISA as a shield for employers, insurance companies and plan administrators.

discretionary authority to decide benefit eligibility within the terms of the trust.[6]

The Fifth Circuit in *Pierre* incorrectly applied *Firestone* in requiring deference to factual determinations made by fiduciaries, even though the terms of the Plan did not grant the decisionmaker authority to make final and binding factual determinations. This Court recently stated that its decision in *Firestone* "recognized that an ERISA plan could be designed to grant 'discretion' to a plan fiduciary, deserving deference from the court reviewing a discretionary judgment . . . ." *Rush Prudential HMO, Inc.*

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[6] Jay Conison, *Suits For Benefits under ERISA*, 54 U. Pitt. L. Rev. 1, 58 (1992):

> The Court's assumption that benefit suits are review proceedings appears to be yet another case of blind adherence to received tradition. This is most unfortunate. A review proceeding is one for the correction of errors. It is not a proceeding for the original determination of facts or rights and necessarily is more limited than the proceedings to be reviewed. Its scope will depend, possibly in large part, on considerations other than ascertaining truth or settling a dispute. In particular, it will depend on institutional considerations, such as the respective roles and competencies of the initial and reviewing decisionmakers, and the need for efficiency and fairness in the system. By requiring suits for benefits to be treated as review proceedings, the Supreme Court required their form and scope to be guided by considerations other than the correct determination of benefit entitlement. Yet by failing to identify the policies and considerations that might properly determine that character of review, the Court invited indiscriminate reliance on non-ERISA considerations.

v. Moran, 122 S.Ct. 2151, 2002 U.S. Lexis 4644, 50 (2002). But "ERISA itself provides nothing about the standard" much less "directly providing a lenient standard for judicial review of benefit denials . . . ." *Id.* at 52 The Fifth Circuit, in this case, elevated deference to an Eleventh Commandment, requiring claimants to prove that a claims-adjustor's factual decision was an abuse of discretion even where the Plan granted no discretion to the claims-adjustor, the insurer contractually prohibited the claims-adjustor from approving the claim, and the claims-adjustor insisted it was not an ERISA fiduciary or Plan Administration.

Today, most employers offering funded welfare benefit plans do so by purchasing insurance. Employees usually pay part of the insurance premiums. The Future Equipment Plan required employees pay 25% of the premium for coverage, 35% for their dependent coverage. (R.195) The Department of Labor, Bureau of Labor Statistics,[7] reports that from 1988 to 1997, the percent of employees of medium and large private employers who were covered by medical care fee-for-service plans, which would include employer funded and administered plans, fell from 74% to 27%, while employees covered by HMO's increased from 19% to 33%, and employees covered by preferred provider organizations increased from 7% to 40%.[8] During that period, the employees who

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[7]U.S. Dept. of Labor, Bureau of Labor statistics, Employee Benefits Survey, available at http://data.bls.gov/cgi-bin/survemost.

[8] The Benchmark policy was a Preferred Provider Plan, with a $500 deductible providing 80/60% coverage with co-pay, which means 80% payment for those in the PPO group, 60% payment if not. (R.196)

were required to contribute toward the cost of their medical care benefits increased from 44% to 69%. By contrast, from 1992 through 2001, private employers' contributions to healthcare benefits declined from 6.3% to 5.6% of employees' total compensation.

Though the work-world has changed, ERISA has not. Employees are not treated as insureds under insurance policies; instead the trust analogy still applies, resulting in insurers and their claims-adjustors *ipso facto* being deemed fiduciaries, their own disclaimers notwithstanding, vested with discretion to decide facts, whether the Plan has agreed to that or not. Particularly in the Fifth Circuit, insurers are treated without question like trustees, and employees cannot sue for breach of contract and ever have a court resolve factual disputes on the merits if they disagree with an insurer's decision. The Fifth Circuit prohibits breach of contract suits on a *de novo* standard of review to resolve benefit eligibility disputes. And that is wrong.

The "practical reasons" the Fifth Circuit relied on to justify the deference given to denial-of-benefit decisions, when those decisions are contested by insured employees, should trouble this Court. The Fifth Circuit candidly stated these practical reasons in *Pierre*, first bemoaning the large number of claims that must be decided.[9] If courts reviewed *de novo* insurers' decisions denying employees' benefits and tried to decide which party was right, the

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[9]Between 1996 and 2000 (five years), 1,317,734 civil cases were filed in all federal district courts, of which 47,731 (3.6%) were ERISA cases. *2000 Annual Report of Director, Judicial Business of the United States.* ERISA cases constitute a small percentage of civil cases.

Fifth Circuit lamented, judges would become "resolvers of mundane and routine fact disputes."[10] *Pierre, 932* F.2d at 1559. This is not a good reason to adopt a rule that insurers' decisions are entitled to deference. If the insured personally purchased the insurance, rather than paying for it with a wage deduction at work or earning it by working for an employer, any dispute between the insured and insurer, while equally mundane, would have to be decided by a court based on true facts and impartial policy interpretation.

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[10] Chad Baruch, *The Widening Gyre: The Illusionary Promise of Meaningful Judicial Review of ERISA Benefit Denial In the Fifth Circuit*, 25 S.U. .L. REV. 99,116 (1997):

> The Fifth Circuit's focus on concerns of expediency and a potential litigation increase was misplaced. This very argument was rejected in Firestone. Firestone advanced the argument that employers would face more benefit challenges with higher costs , and might even be deterred from offering benefit plans. The Court disagreed by reiterating the ability of the parties to continually determine the standard of review. The Court also found this potential threat of litigation insufficient to warrant adoption of a deferential standard of review for all cases, stating that "the threat of increased litigation is not sufficient to outweigh the reasons for a de novo standard." Of course, the fear of a litigation flood is misplaced. Employers draft the plans and - so long as they comply with ERISA - can amend them to afford administrator discretion. More important, this argument would not - even if it were true - outweigh the need to protect ERISA beneficiaries. This protection is the central goal of ERISA, the very reason for its enactment. If inconvenience to employers is the cost of this protection, so be it (that is, in fact, largely the philosophy underlying ERISA).

Then there are *Pierre's* unabashed "considerations of expediency" that justify "deference to factual determinations made in the administration of the plan." *Id.*[11] If insureds could get federal trials to arrive at the truth, this would encourage "vast numbers of claims," "increase litigation," and "reduce the size of the fund from which benefits are paid." *Id.* One can hardly dispute, that if courts always defer to insurers' or their claims-adjustors' factual decisions, even if mistaken, the insurers' pot will grow, and the insureds, physicians, and hospitals will suffer from non-payment. But Congress imposed on federal courts jurisdiction over mundane ERISA claims. It is not for the courts to reduce the scope of their jurisdiction to resolve these disputes by creating a

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[11]Joseph Cunningham, *ERISA: Some thoughts on Unfilled Promises*, 49 Ark. L. Rev. 83, 90 (1996):

> The Fifth Circuit concluded that "expediency, therefore, forces courts to defer to the factual determinations of plan administrators." Expediency aside, it is far too artful to suggest that all such disputes over plan entitlements are either "mundane" or "routine." More to the point, plan administrators can hardly be considered disinterested adjudicators when their very employment depends on the severity of their claims handling practices. More often than not, the factual investigation by an insurance company staff is aimed at buttressing the decision to support administrative denial of the claim for benefits, with little or no evidence obtained from the participant - a participant who is usually unrepresented by counsel. This "kangaroo court" exercise then produces a report for the court's consideration which often instinctually wants no part of the claims-decision making process, and has ample precedent to avoid it. Only the employee, and justice, suffer.

substantive rule of law under which insurers almost automatically win, thereby discouraging claimants' lawsuits.

The ink was hardly dry on *Bruch* when *Pierre* was decided. There was no Plan in *Pierre*, just an insurance policy, insurer, and insured. ERISA was used to superimpose over the ordinary one-sided, insurer-insured relationship the dissimilar roles of insurer-trustee, insurance policy-plan, and insured-beneficiary. Trust law was applied to an insurance dispute to enhance the factual decision of the insurer to one entitled to deference by the courts. Worse still, this deference was due even though the plan contained no language agreed to by the employee-insured or employer-plan sponsor that reflected that as purchasers of this insurance they agreed the insurer's decision on benefits was to be deferred to when it came to deciding the facts. Nonetheless, the Fifth Circuit concluded: "we hold that for factual determinations under ERISA plans the abuse of discretion standard of review is the appropriate standard: that is, federal courts owe due deference to an administrator's factual conclusions that reflect a responsible and impartial judgment." *Pierre,* 932 F.2d at 1562. This should be reversed.

III. The Extension of *Pierre* to Require Deference to Decisions of Those Disclaiming Any Fiduciary Role Under ERISA Nullifies the Role of Federal Courts In Deciding Disputes. Those who represent and agree they will not act as plan administrators or fiduciaries for ERISA purposes should be taken at their word. In the documents they drafted, CBSA and Benchmark thought it in their interest to expressly require the employer to recognize that Benchmark and CBSA were not plan administrators or

fiduciaries for ERISA purposes.[12] They should not be able to reverse positions when it suits them. Nonetheless, defendants contended that all the documents in which CBSA and Benchmark disclaimed they were Plan administrators or fiduciaries for ERISA purposes were illegal in that regard and void, arguing that Benchmark and CBSA "may not exonerate themselves of fiduciary, responsibility. 29 U.S.C. § 1110(a)." (R.1093)

The trial court circumvented the effect of the disclaimers by declaring illegal and void the disclaimer that CBSA was not a fiduciary under ERISA, and accepting the Defendants "concession" that CBSA was a fiduciary. If the disclaimers by Benchmark and CBSA are illegal and thus void, the logical conclusion is that CBSA should have acted as a fiduciary toward the Plan and Tedford, not that it did act as a fiduciary toward the Plan and Tedford.[13] Cases in which courts have held

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[12]Professor Kathryn Kennedy reports that insurers and their adjustors may find disclaimers of fiduciary obligations beneficial:

> Even if a third-party administrator is used, the employer may decide to reserve the power to interpret provisions of the plan and to determine eligibility. In fact, third-party administrators not wishing to become fiduciaries may insist that such discretionary powers be reserved to the plan sponsor.

Kathryn Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases,* 50 Am. U. L. Rev. 1083, 1116 (1999); *see also, Reddal Indus. v. Wiegand*, 878 F.Supp. 1026, 1032 (E.D. Mich. 1995).

[13]CBSA was not a defendant, and no evidence was presented that it renounced its disclaimer of a fiduciary role, or that it acted as a fiduciary. On summary judgment the defendants should have been required to prove CBSA was acting impartially and fairly as a fiduciary toward Tedford. It was not enough to prove what CBSA said it would do was illegal for it to do. Just because it is illegal to steal cars does not mean there are no car thieves.

disclaimers void are ones where a suit was brought claiming the defendant was liable to the plan because of a breach of fiduciary duties and the defendant sought to avoid liability based on its disclaimer. *See IT Corp. v. Gen. Am. Life Ins. Co.*, 107 F.3d 1415 (9th Cir. 1997), *cert. denied, IT Corp.*, 522 U.S. 1068 (1998). Where one should act as a fiduciary, liability for breach of fiduciary duty cannot be escaped by disclaimer of the fiduciary role.

But not all disclaimers of the role of fiduciary are void. In *Wilkinson v. Haworth*, 186 F.Supp.2d 687 (S.D. Miss. 2002) the insurer's disclaimers that it was plan administrator or fiduciary were effective, because it made claims decisions within preapproved guidelines, and, like CBSA, did not exercise discretion over the Plan's assets. *See also, Reich v. Lancater*, 55 F.3d 1034, 1047 (5th Cir. 1995) (one whose disclaimer is "sufficiently limited by a preexisting framework of policies, practices and procedures" is not a fiduciary.) Where, as here, the only issue is whether a court should give deference to a claims-adjustor's decision, the thrice repeated disclaimer by that decision-maker, who had no discretion to approve the claim, that it was not an administrator or fiduciary for ERISA purposes, should be determinative. No deference should be given to its decision denying benefits.

An entity like CBSA, which has not been delegated discretion to independently and finally decide claims cannot be a plan fiduciary. *See Baker v. Big Star Div. of Grand Union Co.*, 893 F.2d 288, 290 (11th Cir. 1989). The duties a fiduciary has under ERISA § 404(a)(1) require that the fiduciary act in the interest of the participants and beneficiaries. The fiduciary shall insure that the plan is "for the exclusive purpose of: (1) providing benefits to participants and their beneficiaries." *See Clark*

v. Washington Teamsters Welfare Trust, 8 F.3d 1429, 1432 (9th Cir.1993). ERISA § 503(2) requires that the employee have the right to appeal the denial of benefits to "the named fiduciary." 29 U.S.C. § 1133 Where, as here, the entity deciding benefit eligibility is constrained by its agreement with the insurance underwriter not to approve large claims unless they are first approved by the insurer, then the decision-maker cannot be an ERISA fiduciary to plan participants. Its decision is not binding on the insurer, and should not be binding on the participant.

CONCLUSION

The judgment below should be reversed. The case should be remanded to the trial court for further proceedings conducted in accordance with this Court's decision.

Respectfully submitted,

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September 11, 2002

Supreme Court, U.S.
FILED

02 412 SEP 12 2002

OFFICE OF THE CLERK

No.

IN THE

Supreme Court of the United States

KIRK TEDFORD,

Petitioner,

v.

BENCHMARK INSURANCE COMPANY AND THE FUTURE EQUIPMENT COMPANY, INC. EMPLOYEE WELFARE BENEFIT PLAN

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

APPENDIX

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38 pp

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 01-10995

KIRK TEDFORD

Plaintiff-Appellant-Cross-Appellee

versus

BENCHMARK INSURANCE COMPANY; FUTURE EQUIPMENT CO.,

Defendants-Appellees-Cross-Appellants

Appeals from the United States District Court
for the Northern District of Texas
(4:00-CV-1695-BE)

Before WIENER and DENNIS, Circuit Judges, and DUPLANTIER, District Judge. PER CURIAM:

Plaintiff Kirk Tedford was a participant in an employee welfare benefit plan ("the plan") sponsored by his employer, defendant Future Equipment Company, Inc. ("Future Equipment"). The plan is governed by the Employee Retirement Income Security Act (ERISA)(29 U.S.C. §1001 et seq.), and is covered by a group policy underwritten by defendant Benchmark Insurance

Company ("Benchmark"), issued through the National Healthcare Trust, and administered by Corporate Benefits Services of America, Inc. ("CBSA"), an independent third-party contractor which serves as ERISA plan administrator for numerous plans. Discretionary authority for processing and settling claims of participants and beneficiaries under the plan was duly delegated to CBSA.

While covered by the plan, Tedford wrecked his motorcycle in a single vehicle accident at about midnight of the day in question and sustained severe injuries. Shortly after being airlifted to a hospital, Tedford's blood and urine were tested, revealing the presence of amphetamines, opiates, benzodiazepines, and alcohol. Tedford's blood alcohol level was 142 mg/dL; the laboratory report noted that levels in excess of 100 mg/dL fall in the "may be intoxicated" range. In the exercise of the delegated discretion, CBSA denied Tedford's claims of more than $220,000 for medical bills and expenses. That decision was grounded in the plan provision that states "Benchmark shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician." CBSA denied Tedford's claim after reviewing only written reports and records.

In pursuing an administrative appeal of the denial of benefits, Tedford's attorney wrote a letter to CBSA stating that "Kirk Tedford was not under the influence of narcotics when he was injured" and that "[a]ny narcotics in his system were result of medication" administered after the accide t. Tedford's counsel also advised CBSA that "Kirk Tedford was not intoxicated, and any alcoholic

beverage he consumed prior to his injuries did not cause those injuries." CBSA denied the administrative appeal.

Tedford then filed the instant action against his employer and Benchmark, the insurer, to recover for his medical bills and expenses. Only then did Benchmark investigate Tedfords representations that any narcotics in his system were administered by medical personnel after the accident, a fact confirmed by the expert retained by Benchmark.

The district court granted the defenants' motion for summary judgment.

I
SUMMARY JUDGMENT

We have reviewed de novo the appellate record in this summary judgment case, carefully considering the applicable facts, as well as the law as set forth in the opinion of the district court, the briefs of the parties, and the oral arguments of counsel. As a result, we are convinced that the district court was correct in all of its rulings and in its grant of summary judgment in favor of the defendants.

A. Standard of Review

Initially, Tedford urged the district court to review the plan administrator's determination de novo. Tedford advanced this position despite the fact of the plan's delegation of discretionary authority to CBSA and the settled law that in reviewing interpretation by a plan administrator vested with discretion, courts can consider only such evidence as was available to the administrator and must review it under the deferential, abuse-of-discretion standard. In ERISA cases, that standard requires that all interpretations of the plan and determinations of eligibility for benefits by the plan

administrator be affirmed unless found to be arbitrary or capricious.[1]

B. Conflict of Interest

Tedford asserted that Benchmark or CBSA, or both, have conflicts of interest in this matter. Tedford is incorrect. Benchmark remains an ERISA fiduciary but is bound to pay or deny claims based on CBSA's discretionary calls. CBSA is an arm's-length contractor, wholly independent of Future Employment and Benchmark. CBSA does not labor under any conflict of interest for purposes of ERISA, and thus is not subject to the sliding scale analysis under the rubric of our opinion in Vega v. National Life Ins. Servs.[2] The district court correctly determined that Tedford has demonstrated no legal or factual basis for claiming that any such conflict of interest was present.

C. Investigation

The district court was also correct in rejecting Tedford's claims of inadequate investigation by CBSA and lack of factual support of its ruling. We agree with the court's ultimate legal conclusion that "the summary judgment record does not demonstrate that Defendants acted arbitrarily and capriciously or committed an abuse of discretion in determining that Tedford's injuries were a consequence of circumstances that render him ineligible for coverage."

We need not address the remainder of Tedford's contentions; suffice it to say that we are not persuaded that

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[1]See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113-15 109 S.Ct. 948 (1989); Estate of Bratton v. National Union Fire Insurance Co., 215 F.3d 516 (5th Cir. 2000).

[2]188 F.3d 287 (5th Cir. 1999)(en banc).

the district court erred in rejecting those contentions and dismissing Tedford's action.

II

ATTORNEY'S FEES

As counter-appellants, the defendants seek reversal of the district court's refusal to award them attorneys' fees and costs pursuant to § 502(g) of ERISA. (29 U.S.C. §1132(g)(1)). We review the district court's denial of defendant's request for attorneys' fees for abuse of discretion. Lain v. Unum Life Insurance Co., 279 F.3d 337, 343 (5thCir. 2002).

In analyzing defendants' request for attorney's fees, the district court applied the five factors announced in Iron Workers Local No. 272 v. Bowen[3]:

> (1) The degree of the opposing parties' culpability or bad faith;
> (2) the ability of the opposing parties to satisfy an award of attorney's fees;
> (3) whether an award of attorneys' fees against the opposing parties would deter other persons acting under similar circumstances;
> (4) whether the parties requesting attorneys' fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant question regarding ERISA itself; and
> (5) the relative merits of the parties' position.
>
> "No one of these factors is necessarily decisive, and some may not be apropos in a given case, but together they are the nuclei of concerns that a court should address in applying section 502(g)." Id.

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[3]624 F.2d 1255, 1266 (5th Cir. 1980).

The first Bowen factor examines the degree of the opposing party's culpability or bad faith. The district court concluded that there was no evidence that Tedford acted in bad faith, but the court did not conduct a detailed analysis of Tedford's culpability, despite the disjunctive nature of the first Bowen factor. However, it is readily apparent that the district court considered and rejected the conclusion that Tedford was culpable. In evaluating his claims, the district court concluded that Tedford presented "legitimate, albeit ultimately unsuccessful complaints regarding the way in which his case was handled, the completeness of the administrative record, and the manner in which his concerns and those of his attorney were addressed." Such complaints are not frivolous in nature. Additionally, in analyzing the third Bowen factor, i.e., whether an award of fees would deter persons acting under similar circumstances, the district court noted that that factor "carries less force because there is no finding of bad faith or culpability so that there is less negative behavior for an award of fees to deter." Considering the district court's opinion as a whole, and the deference to which the district court's decision is entitled, the court did not abuse its discretion in concluding that the first factor did not weigh in defendants' favor.

We note that although the first factor is phrased disjunctively ("culpability" and "bad faith") the definitions of the terms "culpability" and "bad faith" are similar, and thee is apparently no Fifth Circuit precedent explaining the difference, if any, between the two terms in this context. As used in *Bowen*, 642 F.2d at 1266, the terms may have been used synonymously.

As for the second factor (the ability of the opposing party to satisfy an award of attorneys' fees,) the district

court correctly concluded that this factor did not weigh in favor of an award of attorneys' fees. The record contains no evidence indicated that Tedford, faced with significant unreimbursed medical expenses, has the resources to satisfy an award of attorneys' fees.

Considering our analysis of the merits of Tedford's claims there can be no doubt that the district court correctly weighed the fifth Bowen factor in favor of defendants.

The district court also concluded that the third factor (whether an award of attorneys' fees against the opposing party would deter persons acting under similar circumstances) weighed in favor of an award of attorneys' fees. However, the district court accorded that factor less weigh in ultimately determining defendants' entitlement to attorneys' fees, concluding that Tedford's lack of bad faith or culpability meant that there was "less negative behavior for an award of attorneys' fees to deter." We find no fault in that analysis. In Harms v. Cavenham Forest Industries., Inc., 984 F.2d 686, 694 n. 12 (5th Cir. 1993), this court recognized that there is a "lack of bad faith or culpability" in the pursuit of the claim for ERISA benefits "the deterrent purpose that the third *Bowen* factor purports to serve" is applicable.

Defendants concede that the fourth Bowen factor has little relevance. Accordingly, we do not consider it.

The district court concluded "that the collective circumstances do not favor an award of attorneys' fees." We find that the district court did not abuse its discretion in denying an award of attorneys' fees.

We AFFIRM the judgment of the district court.

THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

KIRK TEDFORD,	§	
PLAINTIFF,	§	
	§	
VS.	§	CIVIL ACTION NO.
	§	4:00CV- 1695-BE
	§	
BENCHMARK	§	
INSURANCE CO., ET AL.	§	
DEFENDANTS.	§	

MEMORANDUM OPINION AND ORDER

Plaintiff Kirk Tedford has filed suit against Defendants Benchmark Insurance Company and the employee benefits plan sponsored by his previous employer, Future Equipment Company, Inc. for the denial of health care insurance benefits. The parties have filed cross-motions for summary judgment. Having reviewed the arguments and summary judgment record, the court finds that Defendants' Motion for Summary Judgment is meritorious and that Plaintiff's Motion for Summary Judgment should be denied.

A. FACTS AND PROCEDURAL HISTORY

Kirk Tedford was a participant in an employee welfare benefit plan established by his employer, Future Equipment Company, Inc. Future Equipment purchased a health insurance policy from underwriter Benchmark Insurance Company. Benchmark assigned the responsibility for claims administration under the policy to

a third company, Corporate Benefit Services of America, Inc. (CBSA). Benchmark granted CBSA discretionary authority in processing and settling insurance claims for Future Equipment employees. (Def. Mot. Summ. J., App., Ex. A).

Tedford was involved in a one-vehicle motorcycle accident on November 6, 1999 at approximately 12:05 am. (Def. Mot. Summ. J., App., Ex. D-3, p. 322). Tedford was thrown from his motorcycle and sustained a serious head injury. He was airlifted to a local hospital, underwent surgery and remained unconscious for three weeks.

Tedford was given blood and urinalysis tests at approximately 12:30 a.m. on November 6, 2000. Tedford tested positive for amphetamines, opiates, benzodiazepines, and alcohol. (Def. Mot. Summ. J., App., Ex. D-4, p. 335). His blood alcohol level was measured at 142mg/dL. Any amount over 100 ml/dL is referred to as "may be intoxicated" on the laboratory report.(Def. Mot. Summ. J., App., Ex. D-4, p. 335). The laboratory report cautioned that the results were for medical purposes only and not a forensic order. (Def. Mot. Summ. J., App., Ex. D-4, p. 334).

Upon his release from the hospital, Tedford filed a claim with CBSA to recover his hospital bills expenses totaling more than $220,000. After reviewing the accident report and medical records provised by Harris Methodist Hospital, including the toxicology report, CBSA denied benefits to Tedford based on the following provisions in his medical benefits plan:

XI. General Exclusions

. . . .

TT. Health care services resulting or arising from complications of, or incidental to, any health care service not covered under the policy.

. . . .

XVI. General Provisions

. . . .

U. Intoxicants and Narcotics

Benchmark shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(Def. Mot. Summ. J., App., Ex. D-1, pp. 96, 112).

CBSA sent a letter to Tedford on March 21, 2000 denying his benefits. (Def. Mot. Summ. J., App., Ex.B). Tedford filed an appeal with CBSA on April 24, 2000, (Def. Mot. Summ. J., App., Ex. D-5), which CBSA also denied based on the toxicology report and the policy exclusions. (Def. Mot. Summ. J., App., Ex. C). Tedford insists that CBSA abused its discretion in determining his ineligibility for benefits and failed to evaluate all the relevant evidence in denying his claim. Tedford filed suit to recover his benefits in the amount of his medical bills plus reasonable attorney's fees. Benchmark filed a Motion for Summary Judgment and Tedford has responded with his own Motion for Summary Judgment.

B. STANDARDS OF REVIEW

Summary judgment is appropriate if the pleadings, depositions, answers to interrogations, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. FED. R. CIV. P. 56(c); *Celotex Corp. v. Catrett,* 477 U.S. 317, 322,

106 S.Ct. 2548, 2552, 91 L.Ed.2d 265 (1986); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247, 106 S.Ct. 2505, 2509-10, 91 L.Ed.2d 202 (1986).

It is undisputed that Future's employee health insurance program is an employee welfare benefit plan as defined and governed by the provisions of the Employee Retirement Income Security Act (ERISA). *See generally* 29 U.S.C. §§ 1002(1), 1003(a). Nor do the parties dispute that ERISA preempts any state law claims insofar as they relate to an employee benefit plan subject to ERISA. 29 U.S.C. § 1144(a); *Pilot Life Ins. Co. v. Dadeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). Instead, when a beneficiary or participant like Tedford wants what he alleges was supposed to have been distributed under the plan, the appropriate remedy is a claim for denial of benefits under the civil enforcement provisions of ERISA. *See* 29 U.S.C. § 1132(a)(1)(B).

Consistent with established principles of trust law, a denial of benefits challenged under § 1132(a)(1)(B) is reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113-15, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989); *Estate of Bratten v. National Union Fire Ins. Co.*, 215 F.3d 516 (5th Cir. 2000). For purposes of reviewing plan interpretations when the administrator has discretion, the court considers only the evidence that was available to the administrator; but in reviewing interpretations of a plan under *de novo* standard, the court can consider additional evidence that was unavailable to the administrator, *Southern Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 102 (5th Cir. 1993).

Understandably, the Defendants urge that the abuse of discretion standard applies, while Tedford urges that the court should review the denial of benefits *de novo*. Tedford observes that in both the Certificate of Group Insurance and the Subscription Agreement signed by Future, Benchmark denied having any agency relationship with the employer, disclaimed serving in any capacity for purposes of ERISA, and attempted to distance itself, the insurance trust, and its delegated claims administrator from any duties imposed by ERISA. (Def. Mot. Summ. J., App., pp. 34, 37)

The validity of these disclaimers is questionable at best, and in fact, the Defendants now assert that their own disclaimers are void. A disclaimer of the role of plan administrator may be permissible because when no administrator is specifically designed by the plan, the plan sponsor becomes the plan administrator by statute.[1] 29 U.S.C. § 1002(16)(A)(ii), (B). But attempts to renounce a fiduciary role do not appear to be authorized by ERISA. To the contrary, except in limited circumstances not applicable here, a provision in an agreement or instrument purporting to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under ERISA is void as against public policy. 29 U.S.C. § 1110(a). *Cf. Custer v. Pan Am. Life Ins. Co.* 12 F.3d 410, 418 n.3 (4th Cir. 1993)(noting that contractual disclaimer of ERISA fiduciary status should not be determinative, discretionary functions performed should control).

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[1]Although the plan sponsor (usually the employer) becomes the plan administrator unless the terms of the plan designate otherwise. Future Equipment retained no discretion in the contractual administration of the policy, and explicitly advised Tedford that it had no say in the denial of his claim. (Plf. App., Tab 10)

A person is a fiduciary with respect to a plan to the extent that person (1) exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets; (2) renders investment advice for a fee or other compensation, direct or indirect, with respect to any monies or other property of such plan, or has any authority or responsibility to do so; or (3) has any discretionary authority or discretionary responsibility in the administration of such plan. *See* 29 U.S.C. §§ 1002(21)(A)(1999). Under the terms of the insurance policy and related documents in this case, Benchmark reserved the sole and exclusive right to interpret and apply the policy provisions, including the right to make factual determinations, and granted itself the discretion to delegate some of its authority to other persons or entities for administrative purposes, i.e., CBSA.[2] (Def. Mot. Summ. J. App., Ex. D-1, pp. 40-41).

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[2]Tedford correctly notes that CBSA's authority was not co-extensive with Benchmark's. Benchmark did retain some control with regard to the payment of large claims by providing in its agreement with CBSA that

> any single health claim payment in the amount of $10,000 to $24,999 shall be sent to the Company for review after being pain[sic], while any single health claim payment in the amount of $25,000 for [sic] more shall require the Company's [Benchmark's] prior approval before being paid. For any claiment where the diagnosis is such to indicate that the total health claims cost may exceed $50,000, the situation shall be brought to the immediate attention of the Company when Administrator [CBSA] receives notice of the diagnosis.

This provision does not appear to limit CBSA's authority to issue a denial of a particular claim, nor does Benchmark protest that CBSA

This authority bestows fiduciary status on these entities under ERISA definition.

Tedford displays outrage that Benchmark seeks to circumvent its contractual disclaimers of any ERISA responsibility and secure to itself and the plan the more beneficial abuse of discretion standard of review for its plan interpretations.[3] Although a lengthy assessment of public policy concerns could be entertained, such a discussion would be pointless given the true nature of the parties' disagreement. They do not present sophisticated arguments about the correct interpretation of the exclusionary clause or other policy provisions, but center their dispute on the Defendants' factual determinations that Tedford's injuries were a consequence of intoxication or the influence of illegal narcotics. (*See* Plf. Brief 6/28/01, p. 27).

Regardless of the discretion, if any, that the plan grants to its administrator of fiduciaries to interpret the plans terms, the Fifth Circuit holds that factual determinations under ERISA plans are to be reviewed under an abuse of discretion standard. *Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F2d 1552, 1562 (5th Cir. 1991), *cited in Bratton*, 215 F3d at 523. The Fifth

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acted outside the approved limits on its authority.

[3]Benchmark also asserts that only the plan is a proper party in this action pursuant to ERISA's civil enforcement provisions, which provide that "[a]n employee benefit plan may sue or be sued [ ] as an entity." 29 U.S.C.§1132(d). But Defendants cite no authority for the proposition that the plan is the only legitimate defendant in any given case. Benchmark issued the policy and retained almost complete control of the claims process, although it delegated much of its authority to CBSA as claims administrator, and now concedes its role as a fiduciary. Benchmark is a proper party.

Circuit distinguishes *Bruch* as limited to matters of plan interpretation when the facts are not in dispute, and ruled that the federal courts owe due deference to factual determinations made during the benefit review process. *Bratton*, 215 F.3d at 522; *Pierre*, 932 F.2d at 1562. Because Tedford is contesting findings that are factual rather than interpretive in nature, an abuse of discretion standard is appropriate.

C. DISCUSSION

ERISA requires that a claimant be informed of the specific reasons for the denial of his claim, with specific reference to the plan provisions relevant to the denial, and be given opportunity for a full review. *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388, 393-94 (5th Cir. 1998). CBSA notified Tedford in March 2000 that his claim was denied because of the policy exclusions for injuries sustained as a consequence of intoxication or the use of narcotics. (Def. Mot. Summ. J., App., Ex. B). Tedford appealed, but by letter dated July 22, 2000, CBSA again denied his claim based on the same exclusionary provisions. CBSA referred Tedford to the hospital toxicology report and the accident report prepared by the local police department. (Def. Mot. Summ. J., App., Ex. C).

In reviewing whether there has been an abuse of discretion, the court must analyze whether the plan administrator acted arbitrarily or capriciously in making his determination.[4] *Sweatman v. Commercial Union Ins.*

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[4]There is some debate regarding whether the abuse of discretion standard is equivalent to an arbitrary and capricious standard, but the more prevalent view tends to consider it a semantic as opposed to a substantive difference. *See, e.g., Meditrust Financial Servs. v. Sterling Chem.*, 168 F.3d 211, 214-15 (5th Cir. 1999);

Co., 39 F.3d 594, 600 (5th Cir. 1994). A decision is arbitrary only if made without a rational connection between the known facts and the decision or between the found facts and the evidence. *Meditrust Fin. Servs. v. Sterling Chem.*, 168 F.3d 211, 215 (5thCir. 1999) (quoting *Bellaire Gen. Hosp. V. Blue Cross Blue Shield*, 97 F.3d 822, 828 (5thCir. 1996). If a denial is supported by substantial evidence and is not erroneous as a matter of law, it is not arbitrary or capricious. *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 637 n. 12 (5th Cir. 1992).

Because a decision whether an abuse of disecration has occurred is based upon information known to the administrator at the time he made the decision, the court is generally confined to the record available to the administrator when reviewing the factual determinations underlying denial of a claim. *Vega v. National Life Ins. Servs., Inc.,* 188 F.3d 287, 299 (5thCir. 1999)(en banc);*Meditrust*, 168 F.3d at 215; *Schadler*, 147 F.3d at 395. Of course, the court owes no deference to an administrator's unsupported suspicions. *Vega*, 188 F.3d at 302.

Tedford contends that CBSA suffers from a conflict of interest that requires a more rigorous review of its determinations. The Fifth Circuit has adopted a "sliding scale" approach in reviewing the determinations of a self-interested fiduciary. *Vega,* 188 F.3d at 297. Although the standard remains one of abuse of discretion, the conflict is a factor to be considered: The greater the conflict, the less deferential the court's review will be. *Bruch*, 489 U.S. at 115, 109 S.Ct. at 957; *Vega*, 188 F.3d at 297. Tedford, however, has demonstrated no basis for finding a conflict

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Wildbur v. ARCO Chem. Co., 974 F.2d 631, 635 (5th Cir. 1992).

of interest. Tedford observes that CBSA fills several roles and performs multiple functions with regard to the Future Equipment employee benefit plan, but he fails to identify what financial benefit CBSA can expect to gain that would encourage it to deny a claim filed under the plan. CBSA appears to have a purely contractual arrangement between itself and the insurer, Benchmark, that would not create an inference of a conflict of interest. Cf. *Vega*, 188 F.3d at 295, 301. CBSA's schedule of fees for administering Benchmark's insurance policies are generally scaled to the volume of work, the number of plan participants, and the number of hours worked processing or administering claims. Tedford's reasoning that CBSA must be conflicted because of its multiple roles in the administration of the plan is unpersuasive and does not require that a materially lesser level of deference be afforded to CBSA's determinations.

Tedford also criticizes CBSA for conducting an inadequate investigation during the benefit review process, and most notably, for failing to obtain or properly review the Careflight report documenting the emergency treatment he received when he was airlifted from the scene of the accident to the hospital. Additionally, Tedford complains of CBSA's failure to interview him or his attorney about the accident.[5] There is no specific duty to conduct a reasonable or good faith investigation, but as a safeguard, a claimant, a claimant or his attorney may add evidence to the administrative record by submitting it in a manner that gives the administrator a fair opportunity to consider it.[6] *Vega*, 188 F.3d at 298, 300. *See also Gooden*

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[5]Tedford has no memory of the accident. (Plf. App., Tab 20).

[6]Additionally, ERISA provides for the full and fair review of

v. Provident Life & Accident Ins. Co., 250 F.3d 329, 333 (5th Cir. 2001); *Bratton*, 215 F.3d at 512 F.3d at 521 & n.5. If the claimant submits additional evidence to the administrator and requests a reconsideration of his claims, the new evidence is considered part of the administrative record. *Vega*, 188 F.3d at 300.

The court's focus, however, is not on the underlying investigation. Instead, the Fifth Circuit has directed the district courts to consider whether the record that was developed adequately supports the administrative determination. *Vega*, 188 F.3d at 298. The administrator is obligated to identify the evidence in the administrative record, and the claimant may challenge its completeness,[7] but once the administrative record is determined, the district court may not stray from it except in limited circumstances. *Id.* at 299. The only exceptions are for evidence related to how the administrator has interpreted terms of the plan in other instances, or evidence (including expert evidence) to assist the court in understanding medical terminology or procedures. *Id.* The court may not receive outside evidence to resolve disputed material facts,

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any denied claim, 29 U.S.C. §1133(2), but the failure to comply with this provision does not warrant a heightened level of scrutiny-although it may be evidence supporting a finding of abuse of discretion. *Sweatman*, 39 F.3d at 598 & n. 5. Here, CBSA did conduct a review of its initial denial of Tedford's claim at his request and afterwards issued a written decision affirming the denial of benefits.

[7]Tedford has several criticisms of the "administrative record" that the Defendants have provided as part of their summary judgment evidence, and those criticisms will be addressed as relevant to a resolution of the pending motions.

i.e., facts the administrator relied upon to resolve the merits of the claim itself. *Id.*

Tedford asserts that the reason he tested positive for opiates and amphetamines was because of medications given to him by the emergency response team during the helicopter flight to Harris Methodist Hospital. The Careflight report reveals that Tedford was given several medications en route to the hospital (and before being tested), but CBSA either did not have this report or did not appreciate its import prior to denying Tedford's claim. (Plf. App., Tab 14, pp. 123-25). Both Tedford and Benchmark have strayed from the administrative record to supply the court with the March 2001 expert report of toxicologist Eric Comstock, the Defendants' retained expert, who has opined that the positive drug findings were probably cross-reactions or otherwise attributable to the medical treatment Tedford received following the accident .(Def. Reply, App. at 1; Plf. App., Tab 8). The report was prepared after litigation ensued, it was not available to the Defendants at the time the decision to deny benefits was made, and bears on a material issue that Defendants had to resolve in denying Tedford's claim. But even accepting the report as admissible evidence that aids in understanding the relevant medical process, the report does not contradict Tedford's serum blood alcohol analysis that revealed a level of 142 milligrams of alcohol per deciliter of blood. According to Comstock, this blood serum level equates to a probable blood alcohol level between .10% and 14%, and nothing in the treatment records would suggest that the level was due to anything

other than the ingestion of alcoholic beverages.[8] (Def. Reply, App. at 2; Plf. App., Tab 8).

Tedford contends that Mississippi law controls the issue of his intoxication, and that Mississippi forbids using the results of a chemical analysis to deny benefits under an insurance policy. MISS. CODE ANN. §63-11-45 (prohibiting denial of insurance coverage because of test results or refusal to submit to test under implied consent law). Conversely, Defendants urge that ERISA preempts all state law in this instance, but if not, Texas law controls.[9] ERISA preempts all state laws that "relate to" an employee benefit plan except for state laws that regulate insurance. *See generally* 29 U.S.C. §1144(a)-(b)(2)(A). A law regulates insurance when (1) it is specifically directed at the insurance industry; (2) it transfers or spreads policyholder risk; and (3) it affects an integral part of the policy relationship between insurer and insured.[10] *Pilot Life*, 481 U.S. at 48-49, 107 S.Ct. At

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[8]Tedford challenges the completeness and disorder of the administrative record that Defendants have presented to the court, and the courts agrees that the documentation is not a model of organization. But neither the additional documents Tedford now submits as being part of the proper record or his allegations create a material fact issue about the reasonable basis for the determinations relating to his intoxication and the accident or undermine the Defendants' exercise of discretion in denying his claim.

[9]Alternatively, Defendants assert that Texas law should control. This assertion is contrary to Defendants' admission in response to the Interrogatories propounded by Tedford that Mississippi law would control unless preempted.

[10]In addition, when the insurance policy in dispute is part of a plan governed by ERISA, but ERISA does not expressly address the issue presented, then the court must devise federal common law to resolve the parties' dispute and in doing so, may look to state law for

1553-54. But regardless of whether the cited Mississippi law may otherwise survive preemption, it is inapplicable in the instant case. Tedford is relying on Mississippi motor vehicle laws governing public safety procedures and related criminal penalties for a person suspected of driving under the influence of alcohol or controlled substances. He cites no authority for the proposition that criminal provisions relating to breathalyser or blood alcohol testing done by or at the discretion of law enforcement are relevant when he was tested for intoxicants and narcotics by medical personnel and for treatment purposes. Neither ERISA nor the plan provisions require an arrest or conviction of an alcohol-related offence to deny benefits to an injured party. Further, both Texas and Mississippi insurance laws specifically permit and insurer to include an exclusionary provision for intoxication identical to the provision included in the Benchmark policy. *See* MISS. CODE ANN. §83-9-5(2)(h); TEX. INS. CODE ANN. art. 3.70-3(B)(9).

Tedford cannot recall the details of his accident and does not dispute drinking alcohol at some point before his accident-although he denies that he was intoxicated or that intoxication was the cause of the accident, but the exclusionary provision in the policy is not ambiguous and Tedford has created no fact question about Defendants' decision to apply the exclusion to his claim. Although the police report does not indicate that the accident investigator suspected alcohol was a factor, it reflects that

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guidance so long as the state law is not inconsistent with congressional policy concerns. *Todd v. AIG Life Ins. Co.*, 47 F.3d 1448 (5th Cir. 1995); ; *Brandon v. Travelers Ins. Co.*, 18 F.3d 1321, 1325 (5th Cir. 1994); *Pitts v. American Sec. Life Ins. Co.*, 931 F.2d 351, 355 (5th Cir. 1991).

the accident was a one-vehicle accident occurring on a clear night[11] and on a smooth, dry road as Tedford exited from a freeway and hit the curb as he attempted to enter the service road. The Defendants had a reasonable basis for finding that Tedford's losses were sustained or contracted as a consequence of his intoxication in light of the toxicology evidence and the circumstances of the accident. Although the court might have reached a different conclusion, the guiding principle is whether the decision made falls somewhere on a continuum of reasonableness–even if on the low end. *Vega*, 188 F.3d at 297.

Tedford's situation invokes sympathy, but the summary judgment record does not demonstrate that Defendants acted arbitrarily and capriciously or committed an abuse of discretion in determining that Tedford's injuries were a consequence of circumstances that rendered him ineligible for coverage. Summary judgment is appropriately granted for the Defendants.

D. ATTORNEY'S FEES

The Defendants have asked the court to award them attorney's fees in defending this action. ERISA grants the court discretion to allow a reasonable attorney's fees and costs to either party in a civil enforcement action. 29 U.S.C.§1132(g)(1). The Fifth Circuit utilizes a five-factor test for determining whether an award of attorney's fees is appropriate, and considers: (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the

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[11]The accident investigator who prepared the police report erroneously indicated the accident occurred at "0005 P.M." which CBSA initially understood as referring to five o'clock in the evening; however, the accident actually occurred closer to midnight. (Def. Mot. Summ. J., Ex. D-3).

opposing parties to satisfy an award of attorney's fees; (3) whether an award of attorney's fees against the opposing party would deter other persons acting under similar circumstances; (4) whether the parties requesting attorney's fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties [sic] positions. *See Wegner v. Standard Ins. Co.*, 129 F.3d 814, 821-822 (5thCir. 1997); *Iron Workers Local No. 272 v. Bowen*, 624 F.2d 1255, 1266 (5th Cir. 1980). *See also Todd v. AIG Insur. Co.*, 47 F.3d 1448, 1459 (5th Cir. 1995). No one single factor is necessarily decisive, and some may not be apropos at all in a given case, but together they are the core concerns that a court should address. *Wegner*, 129 F.2d at 821; *Iron Workers Local No. 272*, 624 F.2d at 1266.

The first factor identified by the Fifth Circuit relates to culpability, but does not weigh in Benchmark's favor because there is no evidence that Tedfor has acted in bad faith. Tedford has presented legitimate, albeit ultimately unsuccessful, complaints regarding the way in which his case was handled, the completeness of the administrative record, the manner in which his concerns and those of his attorney were addressed. The second factor, Tedford's ability to pay for these attorney's fees, likewise does not support an award to Benchmark. Tedford was out of work for an extended time and has considerable debt involved with his accident. The very reason for his claim against Benchmark was to clear these debts and recover his medical expenses. Although Defendants state that Tedford is capable of paying the fees, no documentation supports their assertion. This factor weighs heavily against an award of fees.

The third factor, pertaining to deterrence, and the fifth factor, which concerns the relative merits of the parties' positions, weigh in favor of awarding Defendants their attorney's fees as evidenced by the granting of summary judgment to the Defendants. The third factor, however, carries less force because there is no finding of bad faith or culpability so that there is less negative behavior for an award of fees to deter. *Cf. Hixson v. Liberty Corp.*, 964 F.Supp. 218, 227 (W.D. La. 1997)(finding that award of fees would not serve as deterrence for future negative conduct because there was no finding of bad faith on part of party against whom the award was sought).

Defendants submit that the fourth factor has little relevance because this is not an action on behalf of other participants or beneficiaries of Future's benefit plan, and no significant question about ERISA itself is in dispute. This factor does not weigh heavily in the consideration of Defendants' request for an award of their attorney's fees.

Upon consideration of all of the foregoing factors, the court finds that the collective circumstances do not favor an award of attorney's fees and that Defendants' request for recovery of their accrued attorney's fees should be denied.[12]

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[12]Additionally, the request for attorney's fees is not supported by sufficient evidence. If an award of fees is deemed appropriate, then the amount of fees is calculated using the lodestar method of reasonable hours worked multiplied by the reasonable hourly rates of the attorneys. *Louisiana Power and Light v. Kellstrom*, 50 F.3d 319, 324 (5th Cir. 1995). The party requesting the fees has the burden of establishing the number of attorney hours expended, and can meet that burden only by presenting adequate evidence from which the court can determine what hours should be included in the reimbursement. *Kellstrom*, 50 F.3d at 324. This type of evidence usually includes contemporaneous billing records, detailed

It is ORDERED that Defendants' Motion for Summary Judgment is granted, except that their request for attorney's fees is denied. Plaintiff's Motion for Summary Judgment is denied.

SIGNED JULY 20, 2001.

/s/
CHARLES BLEIL
UNITED STATES
MAGISTRATE JUDGE

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descriptions of hours worked, and hourly rates. *Id.* Defendants provide an affidavit from counsel asserting only that Benchmark has incurred a total of $18,616.50 in attorney's fees to date and $1,070.49 in costs in defending this action. The documentation does not meet the standard set out by *Kellstrom*. *See also Wegner*, 129 F.3d at 822.

SEC. 402. ESTABLISHMENT OF PLAN.

(a) Named Fiduciary.–

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(2) For purposes of this title, the term "named fiduciary" means fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly.

SEC. 404. FIDUCIARY DUTIES.

(a) Prudent Man Standard of Care.–

(1) Subject to §§403(c) and (d), 4042, and 4044, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –

(A) for the exclusive purpose of:

(i) Providing benefits to participants and their beneficiaries; and

* * * *

(B) with care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims:

* * * *

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with provisions of this title and title IV.

SEC. 503. CLAIMS PROCEDURE.

In accordance with regulations of the Secretary, every employee benefit plan shall –

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Supreme Court, U.S.
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No. 02-412

IN THE

Supreme Court of the United States

KIRK TEDFORD,

Petitioner,

v.

BENCHMARK INSURANCE COMPANY and THE BENEFIT PLAN SPONSORED BY FUTURE EQUIPMENT COMPANY, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

The Petition For A Writ Of Certiorari (the "Petition") filed by Petitioner states that the third party claims administrator, Corporate Benefit Services of America, Inc. ("CBSA"), who denied Petitioner's claim for medical benefits under an ERISA benefits plan was not delegated certain authority. Pursuant to Rule 15.2, Respondents note that the relevant documents delegated the insurer, Benchmark Insurance Company ("Benchmark"), full and complete authority to administer the benefits plan and that Benchmark granted CBSA the discretionary authority necessary to deny Petitioner's claim.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 29.6 of the Rules of the Supreme Court of the United States, Respondents respectfully submit this Corporate Disclosure Statement

Benchmark is the wholly-owned subsidiary of Supermarket Insurance Agency, Inc. ("Supermarket"). Supermarket is privately-held.

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STATUTORY PROVISIONS INVOLVED

Respondents note that the following statutory provisions are also involved in this case: a) 29 U.S.C. § 1110(a) (1998); b) 29 U.S.C. § 1002(16)(A)(i) (1998); c) 29 U.S.C. § 1002(21)(A) (1998).

STATEMENT OF THE CASE

Petitioner has not accurately defined or sufficiently focused the Court nor any court below on the extent of authority granted Benchmark and CBSA in the relevant documents to make factual determinations under the medical benefits plan. Petitioner has also ignored the degree of evidence in the administrative record that clearly demonstrated that his claim for benefits was not covered under the medical benefits plan.

1. The Plan Excluded Coverage For Intoxication.

Although not disputed, the plain language of the insurance policy (the "Plan") issued by Benchmark to the National Health Care Trust (the "Trust") and accepted and paid for by Petitioner should be emphasized: "Benchmark shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician." Record 274, ¶U. Petitioner has never alleged that this exclusion is unclear or ambiguous or that he is not bound by the Plan.

2. Petitioner Was Intoxicated When His Motorcycle Accident Occurred.

Petitioner's accident occurred while he was riding a motorcycle without a helmet, the weather was dry and clear,

and the roadway was dry and smooth. Record 486-487, 559-560. The accident report showed that the accident involved only Petitioner's vehicle and that Petitioner made an improper turn and disregarded posted signs and turn marks. Record 487. The report concluded that these acts contributed to Petitioner's accident. Record 487.

Blood serum tests conducted on Petitioner within twenty-seven (27) minutes of the accident showed positive signs of alcohol, opiates, and amphetamines. Record 486, 496, 770, 999-1000. These test results showed that Petitioner had a blood alcohol level equivalent to .12. Record 486, 496, 999-1000. This exceeds the maximum amount of alcohol concentration for drivers in Texas of .08. TEX. PENAL CODE ANN. §§ 49.01(2)(B), 49.04 (Vernon Supp. 1999).

On the claim appeal to CBSA, Petitioner presented a statement to CBSA stating that, in his opinion, he "was not intoxicated, and any alcoholic beverages he consumed prior to his injuries did not cause those injuries." Record 618. Petitioner admitted in the appeal below that he did not remember the events leading up to the crash.[1]

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1. In Petitioner's brief to the United States Court of Appeals for the Fifth Circuit ("Petitioner's Fifth Circuit Brief"), Petitioner stated "[o]f course, not having seen the accident, and with Tedford having no recollection of it because of his head injury. . . ." Petitioner's Fifth Circuit Brief 42-43.

3. The Third Party Claims Administrator Denied Petitioner's Claim Based On The Intoxication Exclusion And The Test Results.

The Plan provided:

> [Benchmark has] the sole and exclusive right to interpret and apply the policy's terms, conditions, limitations, exclusions and all other provisions of the policy, including but not limited to, making factual determinations under the policy as to whether benefits are payable. At any time, we may, at our sole discretion, give certain discretionary authority to other persons or entities providing administrative services to us in regard to the policy.

Record 202-203. Benchmark contracted with CBSA to act as administrator of the Plan and CBSA agreed to adjudicate claims submitted under the Plan. Record 163-187.

The Administration Agreement between CBSA and Benchmark (the "CBSA Agreement") required CBSA to review and evaluate applications, establish premium rates, bill premiums, (Record 164), terminate and rescind coverage and process, investigate, settle and pay claims. Record 165. The CBSA Agreement appointed CBSA as the administrator of the Plan. Record 163. CBSA exercised and performed its duties in a fiduciary capacity. Record 160. The Certificate of Insurance and Schedule of Benefits provided to Petitioner under the terms of the Plan also stated CBSA would "decide

whether benefits are payable on the charges for covered services submitted to them. . . ." Record 271-272.

While the CBSA Agreement required CBSA to obtain approval from Benchmark for paying a claim over $24,999, CBSA had unfettered discretion to deny claims. Record 165. CBSA reviewed Petitioner's claims twice and denied those claims based on Petitioner's test results and the intoxication exclusion in the Plan. Record 189-190, 192-193. Although he was given at least two (2) opportunities, Petitioner never offered any explanation as to how the accident occurred. Record 189-190, 192-193. He admitted in a statement submitted to CBSA that he had been drinking prior to the accident, (Record 618), and has since admitted that he does not recall the events leading up to the accident or the accident itself. Petitioner's Fifth Circuit Brief 42-43.

REASONS FOR DENYING THE PETITION

This case is not about *Pierre v. Connecticut General Life Insurance Co.*, 932 F.2d 1552 (5th Cir.), *cert. denied*, 502 U.S. 973 (1991) or about a perceived inconsistency among the courts of appeal. The trial court below reviewed the decision to deny Petitioner's claim for benefits and found that the decision was not an abuse of discretion. The United States Court of Appeals for the Fifth Circuit affirmed without reference to *Pierre*.

Petitioner argues that precedent from other circuits mandate that the trial court give a de novo review of that decision. Petitioner has consistently implied that a different result would have been reached had the trial court granted de novo review. That is simply not true.

The ultimate outcome of whether Benchmark or the third party claims administrator, CBSA, should have denied Petitioner's claim for medical benefits will not change regardless of the level of review given to that decision. There is no question that the Plan excluded coverage for losses arising from intoxication and there is ample and clear evidence in the administrative record that Petitioner was intoxicated at the time of the accident and that his intoxication caused the accident. Petitioner had every opportunity to present additional evidence to CBSA in the administrative appeals process, but did not. Petitioner denies intoxication caused his motorcycle accident, but still has not offered any other reason for the accident or any evidence that would permit anyone to determine there was another cause. By acknowledging that he does not recall the accident, Petitioner admits that he can add no further personal knowledge that would change the decision. The result would have been the same at the trial court regardless of the level of review and would not change even if Petitioner were given a de novo review now.

The Plan gave Benchmark discretionary authority to make all decisions concerning the Plan, authorized Benchmark to engage a third party administrator to assist in administration of the Plan, and authorized Benchmark to grant the third party administrator the authority to provide that assistance. Benchmark engaged CBSA, an independent, unrelated and licensed third party administrator, to make certain claims decisions required under the Plan and gave CBSA authority to make those decisions. Under trust law and well-established Supreme Court precedent, the trial court may review CBSA's decision only for an abuse of discretion.

ARGUMENT

I. UNDER *ANY* LEVEL OF REVIEW, CBSA PROPERLY DENIED PETITIONER'S CLAIM.

The Petitioner's arguments are of no moment to the resolution of this case nor do they change its outcome. Regardless of whether *Pierre* is inconsistent with other appellate courts, regardless of whether CBSA is a plan fiduciary under ERISA, and regardless of whether the relevant documents granted CBSA discretionary authority, there is clear and convincing evidence that Petitioner's claim was not covered by the benefits provided under the Plan.

There are several important facts that have never been disputed in this case:

a. The Plan clearly and unambiguously excluded loss arising from intoxication. Record 274, ¶U;

b. Petitioner's blood alcohol tests showed that Petitioner had a blood alcohol level of .12 twenty-seven (27) minutes after the accident. Record 486, 496, 999-1000;

c. The accident report showed that: Petitioner's accident occurred in dry and clear weather and on a dry and smooth roadway; Petitioner was involved in the accident alone; and Petitioner's improper turn and disregard for posted signs and turn marks contributed to the accident. Record 487;

d. Petitioner admitted that he had been drinking before the crash. Record 618, ¶¶3-4;

e. Before making its final decision, CBSA gave Petitioner at least two (2) opportunities to provide evidence for CBSA to consider. Record 189-190, 192-193. Petitioner has since admitted he does not remember the accident. Petitioner's Fifth Circuit Brief 42-43.

Regardless of the standard that any court would have applied to review CBSA's decision to deny benefits, the result would not have changed. There was substantial evidence to support CBSA's factual determination that Petitioner was intoxicated and that his intoxication caused the accident. Even if Petitioner had a de novo review today, nothing would change. Petitioner cannot remember the accident and, almost three (3) years after the accident, has not and could not present any new evidence.

II. THE APPROPRIATE STANDARD TO REVIEW CBSA'S DENIAL OF PETITIONER'S CLAIM IS 'ABUSE OF DISCRETION' AND CBSA DID NOT ABUSE ITS DISCRETION IN DENYING PETITIONER'S CLAIM.

This case is decided by reference to *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) and not *Pierre*. *Firestone* dictates that the trial court review CBSA's decision for an abuse of discretion and the facts of the case show that CBSA did not abuse its discretion.

A. *Pierre* Has A Limited Holding That Does Not Apply To The Facts Of This Case.

Following the Court's decision in *Firestone*, a number of circuit courts of appeal have addressed the appropriate standard of review to be given a fiduciary's factual determinations. Petitioner argues that the Fifth Circuit Court of Appeals' interpretation of *Firestone* in *Pierre* is inconsistent with other courts' of appeal interpretations of *Firestone*.

In *Firestone*, the Court addressed the level of review to be given to claims decisions but *only in the instance where the fiduciary or plan administrator is not given discretionary authority. Firestone*, 489 U.S. at 111 (analogizing trust law and stating "[w]here discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion"); *see also Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2170 (2002) (recently acknowledging de novo review does not apply where plan grants discretionary authority). Thus, *Pierre* and the other circuits' opinions apply only where the fiduciary or plan administrator is not given discretionary authority. *Pierre* does not apply in this case since Benchmark and CBSA had discretionary authority to make factual determinations to deny Petitioner's claim.[2]

Pursuant to the Plan, Benchmark had "the sole and exclusive right to interpret and apply the policy's terms,

2. *Every single case* cited by Petitioner acknowledges that the "abuse of discretion" review is appropriate under *Firestone* where the administrator or fiduciary has discretionary authority.

conditions, limitations, exclusions and all other provisions of the policy, including but not limited to, making factual determinations under the policy as to whether benefits are payable." Record 202-203. The Plan granted Benchmark a full and complete grant of authority as *Firestone* allows. *Firestone*, 489 U.S. at 115 (nothing "forecloses parties from agreeing upon a narrower standard of review").

The Plan also permitted Benchmark, in its sole discretion, to "give discretionary authority to other persons or entities providing administrative services. . . ." Record 202-203. As it was allowed to do, Benchmark engaged CBSA to assist in administration of the Plan and to make certain claims benefit decisions. Record 165. Petitioner argues for a less-deferential standard of review by focusing the Court on the discretionary authority granted by Benchmark to CBSA in the CBSA Agreement (complete discretion to deny claims, but limited discretion to approve claims) rather than the discretionary authority granted by the Trust to Benchmark in the Plan (full and complete authority).

The appeals court below found that CBSA had discretionary authority and applied the abuse of discretion standard. App. 3a ("despite the fact of the plan's delegation of discretionary authority to CBSA").[3] Since there is a finding below of discretionary authority and *Pierre's* holding applies only where there is no discretionary authority, *Pierre* is not relevant to this case.

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3. After analyzing the level of discretion granted CBSA and Benchmark in the relevant documents, the trial court below concluded "[r]egardless of the discretion, if any, that the plan grants" to Benchmark or CBSA, an abuse of discretion standard is applied. Appendix 14a.

Even so, there is no requirement that CBSA have a full and complete grant of authority to perform all functions.[4] Benchmark hired CBSA as its agent only to perform certain functions and gave CBSA the discretionary authority necessary to perform those functions. Petitioner has never alleged that CBSA acted outside its authority.

Firestone noted that "one is a fiduciary to the extent he exercises *any* discretionary authority or control." *Firestone*, 489 U.S. at 113; *see also* 29 U.S.C. § 1002(21)(A) (1998) (noting person is fiduciary if he "exercises any discretionary authority" or "has any discretionary authority"). Reading the Plan and the CBSA Agreement together, Respondent had discretionary authority to make any and all decisions concerning the Plan and it hired CBSA to assist it in making those decisions. Both parties had discretionary

4. In all but two of the cases cited by Petitioner, either the employer or the insurer made the decision to deny benefits and there was no third party administrator acting on authority of the insurer. In *Cleary v. Knapp Shoes, Inc.*, 924 F. Supp 309 (D. Mass. 1996), the court held that a benefits plan that had a "proof of loss" provision did not grant discretionary authority to the third party administrator. In *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288 (11th Cir. 1989), the court held that a benefit plan that allowed the employer to review all of the third party administrator's claims denials did not grant discretionary authority to the third party administrator. The ultimate issue is whether the plan makes it clear to the employee which fiduciary may exercise discretionary power. *See, e.g., Bogue v. Ampex Corp.*, 976 F.2d 1319, 1325 (9th Cir. 1992) ("[w]e do not want to encourage an employer to insulate himself from effective appellate review through the use of vague phrases that fail to make clear to the employees that the employer will have the final determination of benefit decisions"). Here, the Plan made it clear that Benchmark had full and complete authority, but that it may delegate some of that authority away. Record 202-203.

authority: Benchmark had full authority under the Plan and CBSA had the authority under the CBSA Agreement that it needed to perform it's functions.[5] Both Benchmark and the agent it retained to assist in administration, CBSA, were therefore "fiduciaries."

Petitioner argues that Benchmark and CBSA nevertheless disclaimed their fiduciary status. Petitioner's argument is against the clear language of statutes, 29 U.S.C. § 1110(a) (1998), and the case law. *See, e.g., IT Corp. v. Gen. Life Ins. Co.*, 107 F.3d 1415, 1418 (9th Cir. 1997). Petitioner's cases do not support his argument; they hold instead that if you function as a fiduciary, you *are* a fiduciary. Benchmark and CBSA both held discretionary authority and both exercised discretionary authority and therefore both are fiduciaries notwithstanding any attempted disclaimer.

The common law responsibilities of a fiduciary may have required CBSA or Benchmark to police others' use of Plan assets. For example, Benchmark could be liable for the Trust's misuse of Plan assets were Benchmark found to be a common law fiduciary. The ERISA fiduciary has a more narrow responsibility and is responsible only for the actions it takes with respect to the assets it receives in order to pay claims. While perhaps inartful, the disclaimers were merely attempts to limit CBSA and Benchmark from the broader responsibilities incumbent upon the common law fiduciary.

The undercurrent of Petitioner's argument is that, because of the attempted disclaimers and because of

5. Petitioner admits that Benchmark did not have authority to review CBSA's claims denials.

the deference accorded fiduciaries under *Pierre*, Benchmark and/or CBSA somehow acted out of self-interest or in a conflict of interest. *Firestone* itself provides a check and balance to protect against a fiduciary's self-motivation: "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Firestone*, 489 U.S. at 115. Petitioner has never provided a single shred of evidence that demonstrates that CBSA or Benchmark operated impartially or under a conflict of interest and both the lower courts found none existed. Appendix 4a, 16a-17a.

Protection of ERISA beneficiaries and regulation of ERISA fiduciaries is a worthy goal. Petitioner preys on these concerns by arguing fervently that the deferential standard of review permits CBSA or Benchmark to commit a wrong or cause harm. Yet Petitioner never once explains to the Court what wrong Benchmark or CBSA has committed or what harm they have caused. There is plainly no abuse here.

Firestone holds trust principles sacrosanct; the case was founded on the principle that, under trust law, a trustee exercising his discretionary powers is not subject to the court's control except to prevent an abuse of discretion. *Firestone*, 489 U.S. at 112. *Firestone* prevents the Court from disturbing the trust obligations held by Benchmark except for an abuse of discretion. Here, the Plan gave Benchmark very broad and explicit trust powers and permitted Benchmark to delegate some of those powers to its agent and fellow fiduciary, CBSA. Petitioner is asking the Court to undermine its holdings in *Firestone* and to do violence to trust law all in order to receive yet another review of a claim that is clearly not covered. Requiring endless review of

ineligible or spurious claims only further increases the spiraling costs of health care benefits to employers and employees.

B. CBSA Did Not Abuse Its Discretion.

CBSA did not abuse its discretion in denying Petitioner's medical claim. Every appellate court applies some variation of the "reasonableness" standard in reviewing a fiduciary's claims decisions for an abuse of discretion.[6] The Eighth Circuit Court of Appeals perhaps explained the standard best:

> Rather, the proper reading of "reasonable" in the context of trusts and ERISA is "not immoderate or excessive"; that is, a trustee decision is reasonable if a reasonable person *could* have reached a similar decision, given the evidence before him, not that a reasonable person *would* have reached that decision. Put another way, the committee's decision need not be the only sensible interpretation, "so long as its decision 'offer[s] a

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6. *Pari-Fasno v. ITT Hartford Life & Accident Ins. Co.*, 230 F.3d 415, 419 (1st Cir. 2000) (whether determination was "unreasonable in light of information available to it"); *Jordan v. Retirement Comm. of Rensselaer Polytechnic Inst.*, 46 F.3d 1264, 1271 (2d Cir. 1995) ("reasonable interpretation"); *Abnathya v. Hoffman-La Roche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993) ("without reason, unsupported by substantial evidence or erroneous as a matter of law"); *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 233 (4th Cir. 1997) ("reasonable"); *Vega v. Nat'l Life Ins. Services, Inc.*, 188 F.3d 287, 296-297 (5th Cir. 1999) (same); *Carr v. Gages Health Care Plan*, 195 F.3d 292, 294 (7th Cir. 1999) (must be "downright unreasonable"); *Canseco v. Const. Laborers Pension Trust for S. Cal.*, 93 F.3d 600, 605 (9th Cir. 1996) ("reasonable").

> reasonable explanation, based on the evidence, for a particular outcome.' If the committee's decision offers a reasonable explanation, their decision should not be disturbed even if another reasonable, but different, interpretation may be made." In evaluating whether a plan administrator's fact-based disability determinations are reasonable, courts should look to whether the decision is supported by substantial evidence. Thus, under the abuse of discretion standard of review, the district court, in the absence of bad faith or conflict of interest, may overturn a decision of the plan administrator only if it is "'without reason, unsupported by substantial evidence or erroneous as a matter of law.'"

Donaho v. FMC Corp., 74 F.3d 894, 899-900 (8th Cir. 1996) (citations omitted).

In order to find that the decision to deny Petitioner's claim was an abuse of discretion, the trial court need only have found that a reasonable person *could* have found that Petitioner was intoxicated and that the intoxication caused the accident. It is simply not plausible that any trial court could have concluded that the following did not suffice as "substantial evidence":

a. a blood alcohol level of .12 twenty-seven (27) minutes after the accident. Record 486, 496, 999-1000.

b. an accident report showing that: the accident occurred in dry and clear weather and on a dry and smooth roadway; Petitioner was involved in the

accident alone; and Petitioner's improper turn and disregard for posted signs and turn marks contributed to the accident. Record 487;

c. Petitioner's admission that he had been drinking before the crash. Record 618, ¶¶3-4; and

d. Petitioner's failure to provide any other evidence for CBSA to consider after two (2) opportunities. Record 189-190, 192-193. Petitioner has since admitted he does not remember the accident.

There could hardly be any more evidence. The Court should not grant writ of certiorari.

CONCLUSION

Petitioner has offered no compelling reason to grant a writ of certiorari. Contrary to where the Petitioner hopes to lead the Court, the facts of this case do not reach *Pierre*. Regardless of whether there is a split in the circuit courts of appeal, the Court need not grant a writ in this case. This case is decided under *Firestone* and without reference to *Pierre*. Because Benchmark and CBSA had clear authority to deny Petitioner's claims, *Firestone* requires that their decisions be reviewed only for abuse of discretion.

If the Court nevertheless wishes to address *Pierre*, this is clearly not the case to do so. There is substantial evidence in the administrative record that CBSA's decision was based on a reasonable review of the facts it learned or that were presented by Petitioner during the claims appeal process. By his own admissions, Petitioner could add no new evidence

to the administrative record even if he received de novo review. Petitioner fails even to allege that CBSA or Benchmark committed an abuse of their fiduciary duties.

While Petitioner may appear to be a sympathetic figure, the Court should recognize that he is asking it to trample inviolate trust principles and to needlessly revisit *Firestone*. The decision to deny Petitioner's claim has now been reviewed by CBSA two (2) times, by a federal district court, and by a federal appeals court. Now he asks for yet another review. Mandating endless reviews of specious claims serves only to further increase the spiraling costs of health insurance. The Court should decline Petitioner's invitation and deny his request for a petition for writ of certiorari.

For all of the foregoing reasons, Respondents respectfully request that this Honorable Court deny the Petition.

Respectfully submitted,

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Supreme Court U.S.
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No. 02-412

IN THE
Supreme Court of the United States

KIRK TEDFORD,

Petitioner,

v.

BENCHMARK INSURANCE COMPANY AND THE FUTURE EQUIPMENT COMPANY, INC. EMPLOYEE WELFARE BENEFIT PLAN

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITIONER'S REPLY BRIEF AND SUPPLEMENTAL APPENDIX

DAVID BROILES
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REPLY

Petitioner acknowledges the Certificate of Insurance excludes coverage where the losses to the insured are caused by the insured's intoxication or use of illegal narcotics. Mr. Tedford contends the accident he was in was not a result of intoxication or drug use. CBSA, Benchmark's claims processor, concluded it was. The issue is whether the claims adjustor's denial of benefits is final and not subject to review in a federal court unless the insured can prove the decision-maker acted arbitrarily and capriciously. The Fifth Circuit says it is, regardless of whether the Plan expressly grants to the decision-maker such a role. Seven other circuits disagree.

Here, Benchmark did not interpret the policy, and it made no factual determinations under the policy as to whether benefits were payable. CBSA, Benchmark's claims adjustor, denied Tedford benefits, even before he filed a claim, and denied his appeal two months after the employer terminated the Benchmark policy, and obtained another policy for the employee benefit plan. Neither Benchmark nor CBSA were ever the Plan Administrator – both three times expressly disclaiming that capacity or role. Nonetheless, Respondents twice assert that CBSA was "administrator of the Plan." (Brief in Opposition at 3) No effort is made to explain why CBSA so often disclaimed any role as plan administrator. The Respondents' record cites show that CBSA was Benchmark's administrator of the insurance policy for very limited purposes, but was not the ERISA Plan Administrator. (Record 163-187)

Respondents assert CBSA had "unfettered discretion to deny claims." (Brief in Opposition at 9) Respondents contend that in spite of its repeated disclaimers that it was

not a fiduciary for ERISA purposes, CBSA "exercised" its discretion to deny Tedford's claim, and therefore was a fiduciary. Having declared CBSA a fiduciary, Respondents, relying on "sacrosanct" trust principles, conclude that CBSA was a "trustee" and its denial of benefits "is not subject to the court's control except to prevent an abuse of discretion." (Brief in Opposition at 12) Regrettably, the Fifth Circuit agrees. But neither Respondent nor the Fifth Circuit explain how "unfettered discretion to deny a claim" can involve discretion at all. "CBSA only had discretion to deny Tedford's claim" is equivalent to "CBSA had no discretion."

CBSA was not a trustee for Tedford as a beneficiary. There is no trust-beneficiary relationship involved here. There is an insurance company issuing a group policy with its claims adjustor denying benefits. In any other identical situation – other than an employer arranged for insurance policy in the Fifth Circuit – the factual disputes between the insured and insurer would be decided in a court based on the evidence and law, as with any other contract claim. That never can happen in the Fifth Circuit district courts as to ERISA covered group insurance policies, because all factual disputes are resolved in favor of the insurer on the unfounded assumption that insurers' claims adjustors are fiduciary trustees. This presumption prevails even if: (1) no language in an ERISA plan accords the adjustor such an exalted status and (2) over the insurer's and adjustor's express disclaimers that they are not fiduciaries or administrators for purposes of ERISA. That is why this Court should grant the petition and resolve the conflict between the circuits against the Fifth Circuit rule.

Respondents argue this case is not about *Pierre v. Connecticut General Life Insurance Co.*, 932 F.2d 1552 (5 th Cir.) *cert. denied*, 502 U.S. 973 (1991), but should be

"decided by reference to *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) and not *Pierre*." (Brief in Opposition at 7). The trial court did not rely on *Bruch*, but relied on *Pierre*, because "the Fifth Circuit holds that factual determinations are to be reviewed under an abuse of discretion standard" while "*Bruch* [is] limited to matters of plan interpretation when the facts are not in dispute . . . ." (App. 14a-15a). The trial court was partially correct; there is no basis in *Bruch* for according factual determination of administrators or claims adjustors any deference.

The Fifth Circuit misread *Bruch* in holding that "[i]n ERISA cases, that standard [abuse of discretion] requires that all . . . determinations of eligibility for benefits by the plan administrator be affirmed unless found to be arbitrary and capricious" citing *Firestone Tire & Rubber Co. v. Bruch* as authority. (App. 3a-4a) *Bruch* affords no authority for the Fifth Circuit rule of deference to all determinations of eligibility. The relevant parts of this Court's decision in *Bruch* are:

- *De novo* review was held to be the proper standard in *Bruch*: "we hold that a denial of benefits challenged under §1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits,"489 U.S. at 115;
- "The trust law *de novo* standard of review is consistent with the judicial interpretation of employee benefit plans prior to the enactment of ERISA. Actions challenging an employer's denial of benefits before the enactment of ERISA were governed by principles of contract law," *id.* at 112;

- This Court rejected Firestone's argument that a "plan administrator, fiduciary, or trustee is empowered to exercise *all* his authority in a discretionary manner subject only to review for arbitrariness and capriciousness," *id.* at 113; because
- "Adopting Firestone's reading of ERISA would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted," *id.* at 113-114.

Employees under ERISA plans in the Fifth Circuit have less protection than they enjoyed before ERISA. Indeed, ERISA, as interpreted by the Fifth Circuit, dictates employees always lose factual disputes. *Pierre* is in direct conflict with *Firestone Tire & Rubber Co. v. Bruch.*

Finally, Respondents repeatedly chastize Petitioner for not proving he was not intoxicated, going so far as to assert that Mr. Tedford "did not remember the events leading up to the crash" (Brief in Opposition at 2) and that he, "almost three (3) years after the accident, has not and could not present any new evidence" (Brief in Opposition at 7). Respondents know this is incorrect, and invite a rejoinder based on evidence that should be admissible, but is not under the Fifth Circuit rule in *Pierre*. Mr. Tedford was deposed on April 30, 2001, by Benchmark's counsel. The Supplemental Appendix, pages 28a - 32a attached, indicate that Mr. Tedford remembers the events leading up to the accident. He remembers a police officer stopping him before the accident, they conversed, and that officer sent him on his way, not believing Mr. Tedford was intoxicated. Nor did the investigating officer of the accident suspect alcohol or drugs contributed to the accident. Mr. Tedford's wife was with him all day. Mr.

Tedford described the scene of the accident, and how this poorly designed off-ramp had caused many accidents. Photos were available to prove his point.

This Court is not being asked to decide whether intoxication caused the accident. The issue is who should decide whether the accident was a consequence of intoxication or drug use, the claims adjustor or district court. Mr. Tedford never had the chance to present to an impartial trier of fact his testimony, call the police officers or firemen, or present his wife's testimony. There was no trial. CBSA denied benefits in March 2000, without ever contacting Tedford. It denied his appeal in July 2000, without ever talking to Mr. Tedford, though he twice wrote and asked if he could provide any additional information. CBSA concluded Mr. Tedford used illegal drugs. This was false. Respondents' own expert proved it false long after Tedford's benefits and appeal were denied, relying on evidence not included in CBSA's Administrative record. Respondents also continually assert that Tedford had a blood alcohol level of .12. (Brief in Opposition at 2,6,14) Respondents' number arises only in a post-denial expert's report, appears nowhere in the administrative record, and given an opportunity at trial, Petitioner will prove the retrograde analysis incorrect. Had Tedford had a trial, maybe the trier of fact would have concluded he was not intoxicated.

Mr. Tedford worked for and paid for insurance. Part of the payment for that insurance was deducted from his check. He and the insurer disagree about whether he was intoxicated, and what caused the wreck. The difference between them is that the insurer's decision is presumed correct in the Fifth Circuit, and whatever evidence Mr. Tedford may have to the contrary is inadmissable in

federal court. And if that is not an abuse of discretion, it is unquestionably a travesty of justice.[1]

CONCLUSION

The judgment below should be reversed. The case should be remanded to the trial court for further proceedings conducted in accordance with this Court's decision.

Respectfully submitted,

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ATTORNEY FOR PETITIONER

November 1, 2002

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[1]SHEPARD'S on LEXIS reflects 95 Fifth Circuit District Court decisions citing *Pierre*, 932 F.2d 1552. A review of those District Court decisions indicates that 59 cited *Pierre* in considering ERISA administrators' factual decisions. All 59 decisions applied the abuse of discretion standard of review to the administrators' factual conclusions. In 59 decisions, the defendants' motions for summary judgment were granted 47 times, or 80% of the time. Plaintiffs' motions for summary judgment were granted 4 times or 7% of the time. Two cases involved summary judgment on part of the claim for both parties. Motions for summary judgment were denied 6 times, for various non-dispositive reasons. In thirteen years, only 5 trials are reported, and Defendants won 4 times. In Fifth Circuit District Courts, plaintiffs do not get trials on factual disputes in ERISA cases. Plaintiffs in 86% of the ERISA in cases in Fifth Circuit District Courts loose when the disputes are factual.

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SUPPLEMENTAL APPENDIX

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Tedford Deposition Excerpts
April 30, 2001

P. 35 line 5:

Q. All right. Tell me now about the design of that intersection.

A. It is fairly unusual, I'd say, in the metroplex to have an exit ramp that turns you out on a two-way service road. I was not familiar with this ramp. After living in this area most of my adult life, I really couldn't ever recall and still don't recall ever taking – had no reason to go to Haltom Road.

And it goes up a slight incline off the freeway and makes a fairly hard curve to the right and dumps you out perpendicular on the access road. And there is a curb, and – the normal highway curb, and directional signs that tell you to make a hard right.

It's a poor design. It's not lit. It dumps you onto a two-way service road. Going back and looking now at the scene, there's car parts all in the ditch from people hitting the curb. The signs are all bent.

The firemen have told me that they have gone and put PVC pipe in the ground so that in the ground so that, when the signs do fly out, they can go over and just set them back in their place. There's a fire station right there on the corner of Haltom Road and 820. You know, normally –

Mr. Broiles: We have some photographs if you want to see photographs.

Mrs. Malone: That's all right. I would just like him to describe it for me. Thank you. I appreciate it.

A. Driving a motorcycle for 31 years, 20 plus on the street, if I ever came near to having an accident, it was another – car involved not watching for motorcycles. You would always watch their hands on the steering wheel, watch their front tires drive defensively on a motorcycle, assuming that they're not going to see you.

So, yes, I would like to think that there was maybe a car coming what I thought was the wrong way down a one-way service road. I didn't know that was a two-way service road – and we were going to have a head-on on the ramp. That's one idea I've had that –

And my wife said that there was a car parked on the service road on the eastbound – headed eastbound. So, when she drove up on the scene, there were already people there. So was this car what I thought was, you know, going to be getting on the freeway going the wrong way and we were going to have a head-on on the ramp? I don't know.

Or did I follow the car in front of me over the curb because the car tracks, skid marks – the signs are bent and twisted and laying down. I mean, it's all there. Did I just follow him over the curb? I don't know. **P. 37, line 12**

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P. 45, line 4

Q. Okay. All right. You indicated in some of the documents that have been filed in this case on your behalf with your signature that — or suggested that perhaps the lab tests indicating that your level of intoxication were wrong. Can you tell me what the basis for that is, sir?

A. Well, it says on the report that it was not taken for forensic purposes. I don't feel like the level that it showed is possible because I had not consumed that amount of alcohol. And over the period of time given, from 2:00 to 11:00, I don't see how it could be possible.

Q. Okay. So basically, you just – you feel that you just did not drink that much alcohol, and you don't think the test results are accurate?

A. Yes. **P. 45, line 19**

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P. 47 line 4

Q. I'm sorry. Will you agree with me that they cite a provision saying they will not be paying for losses sustained or contracted in the accident because of intoxication or influence of alcohol at the time? Is that correct?

A. I suppose. However, you know, if you look at the police report, there's – they had the opportunity to put down there that alcohol or intoxication or – was involved in the accident. And that was not so marked. **P. 47, line 13**

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P. 48, line 17

Q. All right. And you indicated that the police officers did not take any action against you –

A. No.

Q. – as far as DWI or anything like that?

A. No.

Q. Is that true?

A. That's – yes. **P. 48, line 24**

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P. 52, line 14

Q. Okay. And, in Paragraph Number 3 of that same document, you specifically deny that you were under influence at the time of the injury; is that true?

A. Under Number 3?

Q. Yes, sir.

Mr. Broiles: Did you say influence of narcotics or just influence?

Ms. Malone: This one says, was not under the influence of narcotics while –

Q. Is that true?

A. That's true.

Q. Okay. And, again, that is in direct rebuttal of Exhibit Number 1 under the denial where it indicates that they may not pay if it's under the influence of any narcotic. Is that true?

A. Yes, that's true.

Q. Okay. And in Paragraph Number 4 of Page 1, Exhibit 3, you indicate – the appeal indicates that you were not intoxicated

and any alcoholic beverages consumed did not cause those injuries. Is that true?

A. That's true.

Q. And, again, that's in direct rebuttal of what Exhibit Number 1-U says; is that true?

A. That's true. **P. 52, line19**

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P. 77, line 23

Q. When you left Wilhoite's, did you feel like that the alcohol you had consumed that day had impaired your abilities to drive the motorcycles?

A. No, it did not.

Q. Did Zana [wife] say anything to you about your ability being impaired?

A. When I dropped her off at her car, she just told me as usual, "Be careful." And that was it.

Q. Between the time you left Wilhoite's and the time you got back to the sports complex, did you see anyone along the route?

A. No one I knew.

Q. Okay. Did you see anyone –

A. I'm sorry. I'm sorry. Yes, I did – not anyone I knew. But from Wilhoite's back to the stadium, I was pulled over for speeding.

Q. By whom?

A. It was either a North Richland Hills or City of Hurst police officer. I had to bypass the original exit because of traffic to get to where we needed to be. I bypassed it, went down to the next exit ramp, got off. It made me take the longer way back to the stadium. And I got pulled over for speeding, left a red light and had a loud Harley. It was Friday night. And he pulled me over. We talked for 5 or 10 minutes. And there was no citation issued.

Q. Did you get off of the motorcycle or sit on the motorcycle?

A. No. I got off and spoke to him.

Q. Was the officer in an automobile or on a motorcycle?

A. He was in an automobile.

Q. And did he see you walk?
A. Yes, he did.
Q. Did he – was he able to observe your conduct?
A. Yes, he was.
Q. Did he say anything or ask you anything about whether or not you had consumed alcohol?
A. No, he did not.
Q. Did he make any comment in any way relating to intoxicants?
A. No. No, he did not. **P. 79, line 19**